REPORT BY THE

Comptroller General

OF THE UNITED STATES

Legislative And Administrative Changes Needed In Community Mental Health Centers Program

If the goal of establishing a nationwide network of community mental health centers is to be realized in the foreseeable future, legislative and administrative changes must be made in the program. State, local, and third-party revenues (client fees, private insurance, Medicare and Medicaid) must increase so that existing centers may become financially viable and additional centers may be developed.

Although legislation was passed recently which should alleviate many of the problems discussed in this report, additional changes are needed. HEW must also improve program administration.

HRD-79-38
MAY 2, 1979

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-164031(5)

The Honorable Bob Eckhardt
Chairman, Subcommittee on Oversight
and Investigations
Committee on Interstate and
Foreign Commerce
House of Representatives

HSE-02305

Dear Mr. Chairman:

This report is in response to the former chairman's request that we review the community mental health centers program.

The report discusses problems in monitoring the program and the problems encountered by the Department of Health, Education, and Welfare at both the headquarters and regional office level and by the States and individual community mental health centers in complying with the provisions of the Community Mental Health Centers Act, especially those brought about by Public Law 94-63 enacted July 29, 1975. The report contains several recommendations to the Congress for changes in the Community Mental Health Centers Act and to the Secretary of Health, Education, and Welfare to improve program administration.

We obtained written comments from the Department. Their specific comments have been included in the report. As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of the report. At that time we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS, HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

LEGISLATIVE AND ADMINISTRATIVE CHANGES NEEDED IN COMMUNITY MENTAL HEALTH CENTERS PROGRAM

D I G E S T

Administrative and legislative changes must be made if the goal of a national network of community mental health centers ~~to provide mental health care~~ is to be realized within the foreseeable future.

For this planned network to be completed, either

--more funds must be made available to begin new centers;

--a limit must be placed on the maximum grant amount to each center so that the available funds can be awarded to more centers;

--the number of required services must be reduced; or

--some alternative method of funding, such as increased third-party payments, must be found.

The Community Mental Health Centers Extension Act of 1978 (Public Law 95-622, Nov. 9, 1978) extended the program through September 30, 1980, and made changes that should alleviate several problems discussed in this report. (See p. 6.)

As of October 1, 1978, approximately 745 grantees had received planning, construction, and staffing/initial operations grants, and 624 centers were in operation. Of these, 268 had already completed their 8 years of funding eligibility.

PROBLEMS EXPERIENCED
BY CENTERS

The centers GAO visited were experiencing many problems that hampered their effectiveness due, in part, to the limitations on the geographic areas served ("catchment" areas), the complexity and inflexibility of legislative requirements, and the multitude of funding mechanisms and resulting paperwork requirements imposed by the Department of Health, Education, and Welfare (HEW). (See ch. 2.)

Specific problems identified included:

--Some catchment areas which encompass more than one political jurisdiction have been unable to obtain support and coordinate services throughout the entire area; in other areas there had been an unnecessary duplication of services; and still other catchment areas are so large that efficient service delivery is difficult. (See p. 15.)

--Some centers need to improve coordination with both State mental hospitals and Veterans Administration psychiatric facilities. With increased emphasis on deinstitutionalization, the centers' role in providing care after hospitalization is becoming a more critical link. (See p. 18.)

--The 12 services mandated by Public Law 94-63 may not be needed in every catchment area. In addition, the requirement that services offered by centers must be provided in facilities inside the catchment area has resulted in duplication of services and insufficient service in some areas. Although Public Law 95-622 allows centers to share inpatient, emergency, and transitional halfway house services, this requirement should be made more flexible. (See pp. 19 to 22.)

--Eight separate grant mechanisms exist under current legislation. Grantees, although not required by law, in practice submit a separate application for each grant. In many cases grant periods do not coincide with each other. As a result, grantees face a significant administrative and financial burden, reducing the resources available for treatment. (See p. 23.)

NEED FOR ADDITIONAL STATE, LOCAL, AND THIRD-PARTY REIMBURSEMENTS TO ASSURE FUTURE VIABILITY OF CENTERS

The Congress designed Federal support to allow centers sufficient time to develop other sources of funds to replace the declining Federal share of operating funds. State, local, and third-party reimbursements must increase to assure the financial viability of existing centers and the development of new centers. (See ch. 3.)

In the 10 States GAO visited, State funding increased 47 percent from fiscal year 1976 to 1978. However, the cost of health care increased almost 19 percent during the same period. State funding in only 4 of the 10 States increased significantly faster than rising costs. (See pp. 31 to 34.)

Third-party reimbursements--client fees, private insurance, Medicare, and Medicaid--were not major sources of revenue at most centers GAO visited. In fiscal year 1977 at least one-half of the centers received less than 5 percent of total revenues from any one of these sources. Some centers received less than 5 percent from all these sources. Reimbursements from third-party sources were not maximized because of improper planning by the centers or barriers beyond the centers' control. (See pp. 37 to 41.)

The President's Commission on Mental Health made several recommendations aimed at improving third-party reimbursements. In prior reports GAO also recommended that

improvements be made and believes these recommendations are still valid. (See pp. 10 and 61.)

Conversion and financial distress grants have been ineffective as a means for establishing or expanding services on a long-term basis. Over half of the federally funded centers GAO visited have reduced or plan to reduce services when Federal funding ends. Nonreimbursable services, such as consultation and education and assistance to the courts, will be the first to be reduced or eliminated. (See pp. 41 to 43.)

IMPROVEMENTS NEEDED IN GRANT REVIEW, APPROVAL, AND MONITORING PROCESS

Administrative changes are needed to improve the efficiency of the grant review, approval, and monitoring process. Specifically:

--HEW has not issued final detailed program regulations reflecting the changes made by Public Law 94-63, as amended, nor has it issued program guidelines. (See p. 45.)

--Progress is slow in developing program standards to improve the quality of services. (See p. 46.)

--The HEW regional offices GAO visited, with one major exception, were following required policies and procedures for reviewing and approving grant applications. (See pp. 48 to 52.)

--Although considerable attention has been given to the need to monitor centers, annual site visits are not always being made, and grants management officials' participation in site visits is limited. In addition, some States' mental health agency officials, although invited, did not participate in site visits, and HEW regional offices were not always using the headquarters-developed monitoring package. (See pp. 52 to 54.)

--Although center officials were satisfied with the technical assistance provided, they expressed a particular need for more assistance in financial management and in improving third-party collections. (See p. 54.)

--Recordkeeping and reporting on the status of the construction grant program were inaccurate. (See p. 55.)

RECOMMENDATIONS TO THE CONGRESS

GAO recommends that the Congress amend the Community Mental Health Centers Act to:

--Allow the Secretary of Health, Education, and Welfare to waive the requirement for any of the 12 mandated services which a center can demonstrate (1) is not needed, (2) is adequately provided by another organization within the catchment area, or (3) is conveniently accessible outside the catchment area.

--Eliminate the provision for conversion and financial distress grants. If the Congress believes such support is needed, it should explore other methods of providing continuing Federal support.

--Restrict consultation and education grants to organizations not receiving staffing or initial operations grants. Funds for this service could be included in the basic grants.

--Allow HEW to award grants for other than a 1-year period. This change would enable HEW to standardize grant periods and thus reduce the administrative workload on HEW and the centers.

The Congress also should explore development of a funding mechanism that would allow communities which are unable to develop "full service" community mental health centers to provide fewer than the 12 required services. Such a mechanism would allow such communities to provide at least for their highest priority needs.

GAO could, if requested, assist the Congress in preparing the legislative language for implementing these recommendations.

RECOMMENDATIONS TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

GAO recommends that the Secretary:

--Require the National Institute of Mental Health to (1) identify communities that cannot apply for Federal community mental health center funding because of their inability to service the entire catchment area or that, because of the size of the catchment area, cannot economically or effectively provide the mandated services and (2) working with the States, revise catchment area designations to allow those communities to apply.

--Examine, to the extent authorized by the legislation, the need for and feasibility of consolidating or standardizing the grants and grant periods of each grantee to reduce the administrative burden on HEW and the centers.

--Require all regional offices to follow specified procedures for reviewing grant applications.

--Improve reporting and monitoring procedures for the construction grant program.

--Work with the States and the Veterans Administration to assure that community mental health centers have established coordination, screening, and aftercare procedures with State mental hospitals and Veterans Administration psychiatric facilities.

--Prescribe and implement standards to be met by community mental health centers. (See p. 62.)

AGENCY COMMENTS

HEW was in substantial agreement with the basic conclusions of this report but pointed

out that major revisions are forthcoming for the community mental health centers program. As an outgrowth of the efforts to carry out the recommendations of the President's Commission on Mental Health, the Department is proposing new legislation which will address some GAO recommendations and, if implemented, will substantially change the community mental health centers program. HEW did not specify which recommendations would be addressed by this legislative proposal. (See p. 63.)

HEW generally concurred with the recommendations to the Secretary and advised GAO that:

--Communities unable to apply for Federal community mental health center funding will be identified in the development and review of the fiscal year 1980 State plans.

--States will be encouraged to revise catchment areas to comply with the GAO recommendation. HEW added that the legislation being drafted would relax the present requirements and would also authorize development of services for populations and geographic areas that cannot start a comprehensive program.

--An examination will be completed by the end of 1979 to determine the feasibility and need for consolidating grant periods for each grantee.

--Regional offices will be instructed to submit, by the end of fiscal year 1979, a description of current application review procedures to ensure compliance with established Public Health Service review procedures.

--Procedures will be developed by December 1979 to improve monitoring and reporting on the construction grant program.

--Regional offices will be instructed to coordinate with the States to develop screening and aftercare procedures

with the State mental hospitals. The Veterans Administration will be requested to join in a cooperative effort to develop screening and aftercare procedures between centers and the Veterans Administration psychiatric facilities.

HEW, as required by Public Law 94-63, developed and submitted to the Congress in 1977 standards for the care provided by community mental health centers. HEW is exploring the appropriateness of using these standards. This may require field testing and further refinement. HEW said that the Department hopes that a demonstration of Medicare cost-related reimbursements to community mental health centers planned for fiscal years 1979 and 1980 will yield useful input for formulating standards for reimbursement purposes. (See pp. 63 to 65.)

Contents

ABBREVIATIONS

ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
CMHC	community mental health center
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
NIMH	National Institute of Mental Health
VA	Veterans Administration

CHAPTER 1

INTRODUCTION

In February 1963, President Kennedy sent a message to the Congress, expressing his desire to institute a national program to combat mental illness and mental retardation.

The program's primary purpose was instituting comprehensive community care. The President believed that a new type of health facility was necessary, which would both return mental health care to the mainstream of American medicine and upgrade the quality of mental health services.

In his message the President recommended that the Congress (1) authorize grants to the States for constructing comprehensive community mental health centers (CMHCs) beginning in fiscal year 1965, (2) authorize short-term grants for initial staffing costs of CMHCs, awarded on a declining percentage basis over a period of 51 months, and (3) appropriate $4.2 million for planning grants to help prepare community plans for these new facilities.

The President further stated:

> "While the essential concept of the comprehensive community mental health center is new, the separate elements which would be combined in it are presently found in many communities: diagnostic and evaluation services, emergency psychiatric units, outpatient services, inpatient services, day and night care, foster home care, rehabilitation, consultative services to other community agencies, and mental health information and education."
>
> * * * * *
>
> "* * * Long-range Federal subsidies for operating costs are neither necessary nor desirable. Nevertheless, because this is a new and expensive undertaking for most communities, temporary Federal aid to help them meet the initial burden of establishing and placing centers in operation is desirable. Such assistance would be stimulatory in purpose, granted on a declining basis and terminated in a few years."
>
> * * * * *

"I recommend that we make a major demonstration effort in the early years of the program to be expanded to all major communities as the necessary manpower and facilities become available.

"It is to be hoped that within a few years the combination of increased mental health insurance coverage, added State and local support, and the redirection of State resources from State mental institutions will help achieve our goal of having community-centered mental health services readily accessible to all."

In response to the President's message, the Congress passed Public Law 88-164 (77 Stat. 282) the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, which authorized funds for constructing CMHCs.

Since that time the Congress has passed four major legislative changes in the CMHC program. Public Law 89-105 (79 Stat. 427), the Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965, added the authority to make grants to cover a portion of staffing costs for new services provided by CMHCs. Federal support was limited to 51 months and was provided on a declining basis. Regulations promulgated by the Secretary of Health, Education, and Welfare (HEW) required CMHCs to offer inpatient, outpatient, emergency, day care, and consultation and education services.

Public Law 91-211 (84 Stat. 54), the Community Mental Health Centers Amendments of 1970, extended the maximum period of Federal support to 8 years and increased the maximum percentage of support to CMHCs in designated poverty areas. The legislation also authorized specialized programs for the mental health of children and consultation services.

The current provisions of the CMHCs Act, as amended, brought about by Public Law 94-63 (89 Stat. 308) and Public Law 95-622 (92 Stat. 3412), are discussed later in this chapter. A legislative history, which discusses in more detail the major changes in the CMHC program between 1963 and 1978, is included as appendix II.

Responsibility for administering the CMHC program has been delegated to HEW's National Institute of Mental Health (NIMH), one of the three institutes of the Alcohol, Drug Abuse,

DLG 00341

and Mental Health Administration (ADAMHA). While program operations are decentralized, NIMH acts as the focal point at the headquarters level and offers technical assistance to the 10 HEW regional offices. Grant review and approval and grantee monitoring activities are the responsibility of the regional offices.

CURRENT REQUIREMENTS OF THE COMMUNITY MENTAL HEALTH CENTERS ACT, AS AMENDED

Public Law 94-63, for the first time, defined by law what a CMHC should be in terms of (1) essential services provided, (2) organization, and (3) coordination with other mental health services providers. The act required that all centers meet these requirements within specified time frames as a prerequisite for continued Federal funding. Public Law 95-83 extended the CMHC Act and gave some existing centers an additional year to meet the requirements. To meet the definition of a comprehensive CMHC, Public Law 94-63 required centers to offer 12 essential services. The legislation restated the five services previously required by HEW regulations--inpatient, outpatient, emergency, day care, and consultation and education--and added seven additional services

--specialized services for children,

--specialized services for the elderly,

--assistance to the courts for screening residents being considered for admission to State hospitals,

--followup care for persons released from a mental health facility,

--transitional living facilities,

--specialized services for alcohol abuse, and

--specialized services for drug abuse.

Alcohol and drug abuse services, however, could be waived by the Secretary of HEW if a center could demonstrate that the catchment area (the geographic area served by the CMHC) did not need either or both of these services or the need was being met by other organizations within the catchment area. The Secretary did not have the authority to waive the other 10 services.

Public Law 94-63 required that each CMHC be governed by a board of directors made up of catchment area residents who fairly represented the area in terms of sex, age, race, employment, and other demographic characteristics. Further, it required that at least one-half of the members of the board be individuals who were not health care providers. The only exceptions to the governance requirements were centers which were funded prior to the enactment of Public Law 94-63 and operated by a government agency. These centers would have an advisory board which represented the catchment area residents.

The legislation also required CMHCs to coordinate service delivery with other mental health and social service providers in the community.

Public Law 94-63 introduced six new grant categories designed to consolidate and eventually replace the numerous grant authorities under previous legislation.

--Planning grants (section 202) were designed to help a community assess mental health needs in the catchment area and to plan a CMHC program to meet those needs. Each grant applicant would be eligible for one 1-year grant not to exceed $75,000.

--Grants for consultation and education services (section 204) were designed to assist established CMHCs provide consultation and education services to individuals and other mental health providers. Centers which were also receiving operations grants under section 203 could not consider the costs of the consultation and education services and the revenues generated from these services when determining the centers' total operating budgets.

--Conversion grants (section 205) were designed to assist centers funded before the passage of Public Law 94-63 to expand their range of services offered to include the 12 services required to meet the definition of a CMHC. Funding was limited to the operating deficit for those services that the CMHC did not provide before the enactment of Public Law 94-63. Centers were eligible for two 1-year grants.

--Financial distress grants (section 211) were designed to assist financially distressed CMHCs which would otherwise be forced to considerably reduce services.

These grants provided financial assistance to expand mental health services and maintain a level of 12 services without further grant support. Centers which were funded prior to Public Law 94-63 and had completed their 8 years of funding would be eligible for as many as three 1-year grants.

--Facilities assistance grants (section 221) were to pay for a portion of the costs of acquiring, remodeling, or leasing existing facilities. CMHCs in designated poverty areas could use these funds for constructing new or expanding existing facilities. In addition, these grants could pay for the initial equipment of a facility that received financial assistance under this section. To date, no funds have been made available for facilities assistance grants.

--Grants for initial operations (section 203) were designed to help a CMHC meet its cost of operations in providing comprehensive care to the community. Initial operations grants were awarded on the basis of the lesser of (1) the total operating deficit--the difference between the projected cost of operations and funds the CMHC could reasonably be expected to raise from other sources or (2) a decreasing percentage of total cost for the 8-year eligibility period.

Centers funded before the enactment of Public Law 94-63 could elect to continue their staffing grants for the full 8-year term, provided that those centers met the additional requirements (services, governance requirements, etc.) contained in the Public Law within the prescribed time frames. Conversion grants were designed to enable centers to add on any additional services needed to meet the requirement. These centers could also apply for operations grants. Since no center could receive more than 8 years of funding, each prior year of staffing support would count as a year of operations. Thus, centers could receive operations grants to complete the original 8-year term.

In addition to staffing grants to cover the five basic services, Public Law 90-574 and Public Law 91-211 previously authorized specialty grant programs for other services as follows:

--Grants for alcohol and drug abuse services.

--Grants for the mental health of children or "Part F Grants." (Some of these grants were awarded specifically to entities that were not full-service CMHCs to provide children's mental health services. These providers will be referred to as "free standing children's clinics" throughout this report.)

--Grants for consultation services. No funds were ever made available for these grants.

As in the case of other staffing grants, these "specialty" grants were given a full 8-year term and were also subject to a declining percentage basis. If CMHCs elected to continue staffing grant support, any specialty grants would also be continued for the full 8-year term.

Public Law 95-622, approved November 9, 1978, extended the CMHC program through September 30, 1980, and amended existing legislation to allow some flexibility in service delivery. The major changes were:

--New centers will be required to offer only six services when they begin operations--inpatient, outpatient, consultation and education, emergency, followup care for catchment area residents released from other mental health facilities, and assistance to the courts and other public agencies. The other six services must be added within 3 years. As in previous legislation, alcohol and drug abuse treatment services may still be waived by the Secretary of HEW.

--Inpatient, emergency, and transitional halfway house services may be offered outside the catchment area provided they are accessible and are approved by the Secretary.

--Free standing children's clinics are exempt from the requirement that they offer the 12 required services or affiliate with an existing CMHC.

--Centers will be allowed to carry over unexpended grant funds to the next fiscal year. That year's grant award will be reduced by the amount carried over.

--Centers, in certain situations, may retain a portion of unused funds obtained from all sources, provided they can demonstrate to the Secretary that these funds will be used to improve or expand service delivery,

increase the number of patients they are able to serve, modernize their facilities, improve program administration, or establish a financial reserve to offset the future decrease in Federal funding.

FUNDING OF THE CMHC PROGRAM

Since 1965 when the first grant was awarded, the Congress has provided over $2 billion for planning, constructing, staffing, and operating CMHCs. The following table shows, by grant type, the total amounts provided through fiscal year 1977 and the amounts provided for fiscal year 1978.

Funding for the CMHC Program

	Fiscal years 1965-77	Fiscal year 1978
	(millions)	
Construction grants	$ 294.8	$ -
Staffing grants	1,174.7	58.1
Children's grants	123.5	20.6
Initial operations grants	a/127.1	b/157.2
Conversion grants	a/40.0	19.4
Distress grants	a/11.0	5.5
Consultation and education grants	a/12.0	8.2
Planning grants	a/2.5	-
Facilities assistance grants	(a)	-
Total	$1,785.6	$269.0

a/Instituted with the passage of Public Law 94-63, July 29, 1975.

b/Includes $127.6 million for continuation grants.

STATUS OF THE CMHC NETWORK

The Congress' goal in passing the 1963 legislation was to establish a network of CMHCs that would provide community-based mental health care throughout the Nation. As of October 1, 1978, NIMH had funded 745 catchment areas, of which 20 have received planning grants only, 101 have

received construction grants only, and 624 have received staffing or operations grants. The 745 areas represent about 48 percent of the 1,562 catchment areas across the country. Of the 624 CMHCs that received staffing or operations grants, 268 centers had completed their 8 years of eligibility as of October 1978. In addition, five centers ended operations before completing their 8-year term.

The table on page 9 shows the status of the CMHC network in the 10 States visited during this review. These 10 States are ahead of the national average, having completed 55 percent of their networks. Three States--Idaho, Kentucky, and Maine--have established CMHCs in all their catchment areas.

The following table shows the total catchment areas and funded centers in seven HEW regions included in our review. As can be seen 485, or about 48 percent, of the 1,014 catchment areas had received Federal funding at the time of our review.

HEW Regions in Which Work Was Performed

Region	Number of catchment areas	Federally funded CMHCs
I (Boston)	94	58
IV (Atlanta)	231	152
V (Chicago)	326	93
VI (Dallas)	150	83
VII (Kansas City)	87	38
VIII (Denver)	59	40
X (Seattle)	67	21
Total	1,014	485

PLANS TO COMPLETE THE NETWORK

Public Law 94-63 required the Secretary of HEW to submit a report setting forth a plan for completing the CMHC network over a 5-year period. This report was sent to the Congress in July 1976. The report stated that at that time, 860 catchment areas did not have federally funded CMHCs. NIMH projected that to start the 860 needed centers, an investment of $750 million would be necessary, taking into account services that were already available in each catchment area and would not require additional funding.

State	Number of catchment areas	Federally funded CMHCs				
		Total	Graduated	Ongoing	Planning or construction	Provides all 12 services (note a)
Colorado	21	15	10	5	-	3
Idaho	7	7	2	5	-	-
Indiana	32	19	1	18	-	-
Kansas	16	11	1	10	-	7
Kentucky	b/15	15	7	8	-	-
Maine	8	8	1	7	-	1
Massachusetts	41	27	10	10	7	16
Missouri	36	c/13	2	9	1	2
New Mexico	8	5	1	2	2	1
Ohio	80	26	2	16	8	5
Total	264	c/146	37	90	18	35

a/These centers, which are included in the total of 146 centers, were providing at least some level of all the required services.

b/Kentucky actually has 22 "designated" catchment areas. However, the State has converted to a regional system, and the 15 CMHCs provide complete State coverage.

c/Includes one "terminated" center.

We reviewed NIMH planning documents since the passage of Public Law 94-63 and found that completing the CMHC network has been a major objective. NIMH's 5-year forward plan for fiscal years 1977 through 1981 projected a steady expansion of between 75 and 90 new centers each year, resulting in 1,000 operating centers by the end of fiscal year 1981. NIMH's latest planning document, the forward plan for fiscal years 1979 through 1983, envisions a growth of between 75 and 110 new centers each year. This growth rate would result in over 1,000 operating centers by the end of fiscal year 1983 and total national coverage by the end of fiscal year 1988.

Experience with the CMHC program growth rate since the passage of Public Law 94-63, however, has fallen significantly short of all these projections. At that time 603 centers had been funded. In fiscal year 1976, only 34 new centers were started. Only 37 new centers were funded in fiscal year 1977, and 43 new starts were projected in fiscal year 1978. We noted that the President's budget for fiscal year 1979 did not include any funding for new CMHCs. 1/ Since the passage of Public Law 94-63, the average annual growth rate has been only 38 new starts per year. If this trend should continue, the goal of a national network of CMHCs will not be realized until the year 2000.

RECOMMENDATIONS OF THE PRESIDENT'S COMMISSION ON MENTAL HEALTH AFFECTING CMHCs

In its April 1978 report, the President's Commission on Mental Health made 117 recommendations for changes in the way mental health services are provided and financed. Most of the recommendations affect the CMHC program either directly or indirectly.

The 20-member Commission was established by Executive Order 11973, signed by President Carter on February 17, 1977, to review the mental health needs of the Nation and to recommend to the President ways to best meet these needs.

1/Because the program authorization was not approved until November 9, 1978, no funds included in HEW's fiscal year 1979 Appropriation Act were intended to be used for first-year operations, conversion, consultation and education, or financial distress grants. However, funds for these grants were included in a continuing resolution (Public Law 95-482) approved October 18, 1978.

The Commission was organized into 32 task panels which were assigned specific areas of responsibility. The Commission issued a preliminary report on September 1, 1977.

Major recommendations which would affect the CMHC program include:

--Developing a major effort in the area of personal and community support, including improving the links between community support networks and formal mental health services.

--Initiating a new Federal grant program for community mental health services to encourage the creation of necessary services where none exist, supplement existing services where they are inadequate, and increase the flexibility of communities in planning a comprehensive network of services. The Commission recommended an appropriation of at least $75 million for the first year and $100 million for each of the next two years.

--Continuing limited Federal funding for certain services which centers now provide on a nonreimbursable basis.

--Allowing greater flexibility in delineating catchment area boundaries.

--Encouraging sharing of program services between CMHCs.

--Developing a national plan for the continued phasing down and, where appropriate, closing large State mental hospitals; upgrading service quality in those State hospitals that remain; and allocating increased resources for developing comprehensive, integrated systems of care which include community-based services and the remaining smaller State hospitals.

--Creating a new class of intermediate care facilities within the Medicaid program specifically for the mentally ill.

--Requiring any national health insurance program and all existing private health insurance programs and public programs financing mental health care, such as Medicare and Medicaid, to include a reasonable array of benefits for emergency, outpatient, and inpatient care.

--Amending current Medicare legislation so that CMHCs and other organized systems of community mental health care be given provider status; the allowable reimbursement for the outpatient treatment of mental conditions be increased to at least $750 in any calendar year; the beneficiary coinsurance be reduced from 50 to 20 percent to conform to Medicare coinsurance requirements for physical illness; coverage for inpatient care of psychiatric disorders in acute care settings be extended so it is equivalent to that provided for physical illness; and 2 days of partial hospitalization be allowed for each day of inpatient care.

--Amending Medicaid legislation to (1) establish national minimum eligibility standards based on income and assets rather than on categorical requirements so that everyone who satisfied the definition of financial need would be eligible for assistance, (2) establish national minimum mental health benefits to be included in every Medicaid State plan, and (3) remove provisions that allow for any discrimination in allocating services on the basis of age.

--Encouraging States to require that private health insurers offer outpatient mental health benefits.

--Proposing legislation to encourage employers to include mental health coverage in health insurance plans offered to their employees.

The Commission also made some recommendations relating to the availability, training, and qualifications of the mental health staff. Although the Commission report does not specifically say so, apparently its proposed new grant program is intended to eventually replace the existing CMHC program.

PRIOR GAO REVIEWS

This is our third report on the Community Mental Health Centers Program.

Our July 8, 1971, report, "The Community Mental Health Centers Program--Improvements Needed in Management" (B-164031(2)), noted that program planning was inadequate at both the HEW and State levels, HEW had not set goals for implementing the program, and grant funds for both construction and staffing were either greater than warranted or used to cover unauthorized costs.

In our August 27, 1974, report, "Need for More Effective Management of Community Mental Health Centers Program" (B-164031(5)), we pointed out that many of the same problems still existed. Specific findings in that report are discussed in other sections of this report.

In addition to the above reports, our January 7, 1977, report, "Returning the Mentally Disabled to the Community: Government Needs To Do More" (HRD-76-152), noted that central to the process of returning the mentally disabled to the community is the availability of adequate community services. This report discusses the role that CMHCs have played in the deinstitutionalization process.

SCOPE OF REVIEW

We performed our review at NIMH headquarters; seven HEW regional offices responsible for the CMHC program in the 10 States in our review; the State mental health agencies in Colorado, Idaho, Indiana, Kansas, Kentucky, Maine, Massachusetts, Missouri, New Mexico, and Ohio; and at 19 federally funded CMHCs and at 9 nonfederally funded facilities that were providing mental health services in those States. 1/ We also contacted the 19 "free standing" children's grantees by telephone using a structured interview technique.

During the review we spoke with cognizant NIMH headquarters and HEW regional office officials about CMHC program administration and the problems, if any, resulting from the current legislation. We reviewed agency records and files pertinent to planning, grant review and approval, and program administration processes. In addition, we researched the legislative history of the CMHC program to determine the congressional intent.

In each State included in our review, we spoke with State mental health officials concerning the present status and future plans for their CMHC programs.

1/Although the number of centers visited in relation to the total number of centers and catchment areas in the Nation is small, we augmented our observations on these centers by our visits to 10 State mental health agencies, 7 HEW regional offices, and our review of NIMH headquarters records and discussions with headquarters officials. It is our judgment that the centers visited are fairly representative of the total number.

At each CMHC or mental health services provider, we discussed current operations, services provided, financial planning, and future viability when Federal funding support ceases. We also discussed problems encountered with the current legislation, the grant review and award process, and the technical assistance offered by State and HEW regional office personnel.

At 13 centers we reviewed the financial management controls employed. We did not attempt to assess these controls at locations that either had completed their 8 years of eligibility or had not received Federal staffing or operations grants. At six centers our work was limited to an analysis of previous reviews of the centers' financial management controls, including recent years' financial statements prepared by public accounting firms. Deficiencies noted and corrective actions taken or planned as a result of these reviews were discussed with center management officials. Our review disclosed areas in need of improvement: (1) separation of duties concerning cash receipts, disbursements, and accounts receivable, (2) billing procedures for services provided, and (3) separate accountability for individual Federal grants.

We also obtained the views of various advocacy groups who have an interest in the CMHC program.

CHAPTER 2

PROBLEMS BEING EXPERIENCED BY COMMUNITY MENTAL HEALTH CENTERS

The Community Mental Health Centers Act, as amended, places rigid requirements on mental health care providers seeking Federal assistance under the act. Our review showed that some mental health care providers were experiencing difficulties in meeting several of these requirements because of either the inflexibility of the law or the manner in which HEW has interpreted the law. The Congress, in extending the program for 2 years to September 30, 1980, has subsequently eliminated some of the provisions causing problems for the centers.

Many CMHC directors, State officials, and HEW regional office officials we talked to stated that the expanded requirements of the CMHC program created problems in administering the centers because the legislation did not recognize that

- --all the mandated services are not always needed in every catchment area;
- --in some cases adequate service can be provided to catchment area residents from facilities outside the catchment area; and
- --separately identifiable programs for special target groups are not always needed.

In addition, they stated that HEW's adherence to catchment area population limitations sometimes results in an unnecessary duplication of services in urban and suburban areas and creates rural catchment areas which are too large to provide services effectively.

We found that (1) requiring 12 services may be inappropriate in some instances, (2) the multitude of funding mechanisms and paperwork requirements have caused heavy administrative and financial burdens, and (3) centers should be allowed to provide services outside the catchment area in some instances. The latter problem was partially corrected by the 1978 amendments to the act. Also, two other problems

have been corrected by the 1978 amendments. These are (1) some free standing children's clinics would have been forced to curtail services because Federal funding would have been terminated and (2) funds were lost to the CMHC program because there was no legal provision for using unexpended funds in the following grant period.

Finally, although most centers had some type of agreement with State hospitals concerning the admission and release of residents from the catchment area, coordination between centers and State hospitals needed improvement to assure better preadmission screening and aftercare.

PROBLEMS WITH CATCHMENT AREA SIZE LIMITATIONS

HEW has referred to the catchment area concept as a cornerstone of the CMHC program because it focuses a CMHC's responsibility and concern on the mental health needs of the total population within that area. Catchment area boundaries are determined by each State and are based on such factors as existing neighborhoods, planning areas, physical environment, and available resources. However, Federal regulations limit the population of catchment areas to no less than 75,000 and no more than 200,000 persons. Exceptions to these limits may be authorized by HEW if a State so requests, if the exception will improve the effectiveness of the services to be provided. According to HEW, exceptions have been made in more than 10 percent of the catchment areas.

Our August 27, 1974, report to the Congress stated that the limitations on the size of catchment areas had

--impeded program performance by dividing some existing planning areas and political jurisdictions,

--caused services and facilities to be duplicated in some areas, and

--caused spending for mental health services to be unevenly distributed within some political jurisdictions.

Our current review shows that the finding reported in 1974 is still valid in some catchment areas and has been exacerbated by expanding required mental health services from 5 to 12.

One additional catchment area problem not reported in 1974 relates to designated areas encompassing more than one political jurisdiction (i.e., two or three counties). An organization attempting to develop comprehensive community mental health services could be hampered by its inability to obtain support and coordinate services in the entire catchment area.

Although we did not determine whether exceptions were sought, we found situations in which exceptions would seem to be appropriate. For example,

--The Kansas State mental health plan defines one of its catchment areas as encompassing a five-county area of eastern Kansas with a combined population of about 114,000. No federally funded CMHCs are in this catchment area, although the State plan shows CMHCs in three of the five counties. The director of a center serving one county with a population of about 55,000 told us that the facility could not receive Federal funding because the county did not meet the minimum population requirements. She added that efforts to combine several counties to meet minimal requirements have been unsuccessful.

--Johnson County, Kansas, had a population totaling about 218,000 in 1970. The county was divided into two catchment areas because of the 200,000 maximum population limitation. HEW supports comprehensive CMHCs in both catchment areas, and we found that one person serves as executive director of both centers. According to this individual, the Johnson County Commissioners operate both centers, and the same board of directors controls both centers. The executive director stated that two catchment areas in Johnson County require an expensive duplication of services.

--One of the centers we visited in Idaho encompasses a geographic area which covers seven counties and 11,000 square miles. The CMHC has a professional staff of 14 to provide this area's population of about 128,000 with mental health services. Two satellite clinics are maintained in outlying counties but are staffed with only three people at one clinic and one person at the other. The center director stated that trying to provide adequate services to rural communities causes most of the problems.

SOME CENTERS NEED TO IMPROVE COORDINATION WITH STATE MENTAL HOSPITALS

Most centers we visited had some type of agreement with the closest State mental hospital concerning admission and release of residents from the center's catchment area. Some of the centers, however, apparently are much more involved in the admission and release process than others.

Public Law 94-63, as amended, requires CMHCs to coordinate services with other mental health care providers, including State mental hospitals responsible for the center's catchment areas. With the increased emphasis on returning the mentally ill to the community and the need to assure a continuity of services to them, adequate coordination has become more vital.

One Idaho center has a coordinator stationed near the State hospital. The coordinator informs the center when a catchment area resident has been admitted. The center assigns a therapist to each case, who participates in both the treatment program and release planning. When the patient is released, the therapist continues treatment as long as necessary.

We reviewed case files of five patients released by the hospital into the catchment area during November and December 1977. In all five cases clients' records showed information concerning the release and progress since that time.

At an Ohio center we found that coordination was very good. The center has a formal agreement with the State hospital which provides for preadmission screening and interagency referrals. The center has one staff member assigned as liaison with the State hospital to promote interagency communication and coordination services. All 26 patients released into the catchment area during October through December 1977 were contacted by the center staff; of these, 21 were enrolled in treatment, and the other 5 refused treatment.

At other centers, however, coordination apparently is not as effective. A New Mexico center director told us there is little coordination. The center is seldom informed of a patient's discharge and does not participate in release planning. According to the director, the hospital's release summary does not include the patient's address. If the report contains names of patients not previously treated at

the center, the staff has no record to refer to as a means of contacting the individual.

A Kansas center liaison told us that the State hospital sends the center copies of client information forms on patients released from the hospital. He further stated that all identifiable characteristics, including the patient's name, are blocked out. Thus, the center knows when someone from the catchment area has been released from the State hospital but has no way to coordinate aftercare.

The executive director at another Kansas center told us very little coordination exists between the center and the State hospital. He stated that the hospital denied center staff access to any information on patients from the catchment area, and the only coordination that does exist is through a limited referral system.

We also found that coordination with Veterans Administration (VA) hospitals could be improved. Although our review of this area was limited, in many cases centers had made little or no effort to coordinate service delivery with VA facilities. Two centers, one in Colorado, the other in Indiana, had established or were in the process of establishing mutual referral agreements with VA facilities throughout the State. Three other centers' attempts to coordinate service delivery with VA, however, were unsuccessful.

The Deputy Director for Mental Health and Behavioral Science Services, of VA's Department of Medicine and Surgery, told us that VA recognizes the need to coordinate and interact with CMHCs. He further stated that VA's policy is to work closely with State-operated and State and locally supported mental health systems, which would include CMHCs. However, the extent to which CMHCs and VA facilities interact varies among States and centers. In some States the working relationship and coordination is good and in others there is room for improvement.

REQUIRING 12 SERVICES MAY BE INAPPROPRIATE IN SOME CATCHMENT AREAS

At the 7 HEW regional offices and the 10 State offices, we were told that the 12-service model mandated by Public Law 94-63 has created some problems in implementing the CMHC program. HEW and State officials' most common complaint was the difficulty in establishing 12 services within each catchment area. Several officials stated that the 12-service

model is expensive and inefficient because all 12 services may not be needed in every catchment area; services for special target groups, such as children and the elderly, can sometimes be provided without requiring a specialized service program; and the requirement that services be available from within the catchment area prevents CMHCs from sharing services and facilities. Examples of the comments from HEW and State officials follow.

--Officials in three HEW regions stated that the 12-service model expected too much of CMHCs, and all three regions suggested a return to the 5 basic services, or to specified "core" services. Based on catchment area needs and individual CMHC capabilities, additional services could be added. Officials in two of the three regions specifically cited transitional halfway houses and specialized services to children and the elderly as required services creating problems for CMHCs.

--Kentucky officials stated that because the population of the State is predominately rural and poor, State and local community support of the 12-service model is doubtful. These officials believed that CMHCs should only be required to provide services to areas of critical need within local communities and not dilute their programs by providing all 12 services merely to satisfy the requirement of a Federal law. According to these officials, sharing some services should be permitted where they can be adequately provided at reduced cost.

--Indiana told us that, although the State government strongly supports the CMHC program, mandating 12 services at every CMHC is questionable. The State officials believe that more flexibility in the law is needed to allow urban centers to provide more economical services by centralizing or sharing services with nearby centers and to alleviate the difficulties experienced by rural centers in providing specialized staff for each service.

--Massachusetts officials stated that they support most of the concepts of Public Law 94-63 and that, as a result of this act, mental health services have increased, especially for children. However, some State officials believe all 12 services are not needed in every catchment area. These officials cited the situation in Boston where four catchment areas are within a radius of 10 miles.

We interviewed cognizant officials of 19 federally funded or graduated CMHCs regarding the problems created by Public Law 94-63. Officials of 13 centers cited some aspect of the mandatory 12-service model as causing problems. The majority of these officials stated that all 12 services were not needed in the catchment area; some required specialized services either were not needed or were being provided through an existing program; or some services could be adequately provided through facilities outside the catchment area. Examples of the problems cited by CMHC personnel follow.

--The executive director at the Bath-Brunswick CMHC stated that some services, such as transitional halfway houses, could best be provided through shared facilities with centers in other catchment areas. The small population and rural nature of the Bath-Brunswick catchment area does not permit the center to support its own transitional living facility. The executive director added that the diagnostic services for children and the elderly required by Public Law 94-63 are already being provided through the center's inpatient, outpatient, and partial hospitalization programs.

--At the CMHC in Pocatello, Idaho, the program manager stated that providing all mandated services to the rural community was difficult. According to the manager, the CMHC provides 10 services (alcohol and drug abuse treatment are provided through another State agency) but only as part of the original 5 basic services. The program manager classified the children, elderly, and transitional living services as token services which cannot be separately identified in the center's reporting system.

--The Boise, Idaho, CMHC program manager stated that he is having difficulty establishing a separate program for the elderly. Less than 1 percent of the center's clients are 65 years of age or older, and it is difficult to determine their needs. The program manager also stated that the center has not established a transitional living facility because of the high cost and community resistance to such a facility.

--The Maine Medical Center CMHC, which serves a catchment area that includes the city of Portland, completed its staffing grant eligibility in August 1977. The CMHC provides the original five basic mental health services and has chosen not to seek further Federal assistance

because it does not wish to expand its services to include all 12 mandated services. The center's director views the additional required services under Public Law 94-63 as "social services" which are not compatible with the "medical model" approach to mental health services followed by the CMHC. These additional services are provided to the catchment area by the State through the Area V Mental Health Board which contracts with local service provider agencies and organizations. The area board executive director expressed concern about the Maine Medical Center CMHC's status as a graduate center and its decision not to seek further Federal assistance. Maine Medical is the recognized CMHC for the catchment area, and no further Federal mental health funds will be available to Area V unless Maine Medical applies for them. Such an application would, however, require an expansion to the 12-service model.

At the nonfederally funded facilities visited, we did not obtain information on specific instances of adverse effects caused by the required 12-service model, since these facilities need not comply with provisions of Public Law 94-63. However, five directors told us that the 12 specific services were either not needed in their catchment areas or not economically feasible and that each CMHC should have the flexibility to determine what mental health services are needed. In respect to this, the executive director of one CMHC stated

> "Some CMHC's may have 20 essential services, some only one or two - and that could be most appropriate to their needs. Some cannot afford even 12 essential staff, let alone services."

SERVICES PROVIDED OUTSIDE THE CATCHMENT AREA

Section 201 of Public Law 94-63 provided that a CMHC's services could be provided at the center itself or at satellite centers using staff of the CMHC or through appropriate arrangements with health professionals and others in the center's catchment area. Some HEW officials have interpreted section 201 to mean that all 12 essential services must be provided at facilities within a CMHC's catchment area. Others believed that this section is sufficiently flexible to allow a CMHC to use facilities outside its catchment area where it is appropriate to do so. The former opinion is supported by HEW policy established in 1971.

An NIMH official told us that HEW has not formally changed department policy, despite the legislative changes enacted in 1975. Because the issue, prior to passage of Public Law 95-622, had not been resolved, the regional health administrators have been placed in a position to exercise their own discretion in implementing the policy or in allowing services to be provided outside the catchment area when justified.

As an example of a region authorizing services outside the catchment area, we found that four of the services offered by the Northeast Johnson County CMHC were provided by facilities outside its catchment area. The inpatient and partial hospitalization services are provided by a State-operated facility in neighboring Wyandotte County, the emergency services are provided by the University of Kansas Medical Center also in Wyandotte County, and the alcohol detoxification facility operated by the CMHC is in a neighboring catchment area.

The State-operated inpatient and partial hospitalization facility is a branch unit of a State mental hospital and was constructed with the assistance of a Federal CMHC construction grant approved in 1968. The facility serves the clients of both the Wyandotte CMHC and the Northeast Johnson County CMHC. The hospital's operations are partially supported by NIMH staffing grants awarded to Northeast Johnson and Wyandotte CMHCs.

The agreement with the University of Kansas has been in effect since 1968 and, under Kansas State law, the services are provided to the CMHC at no charge. The alcohol detoxification unit was located about 1 mile outside the CMHC's western boundary because no suitable facility could be found within the catchment area.

Public Law 95-622 amended this section to specifically allow grantees to offer inpatient, emergency, and transitional halfway house services outside the catchment area, provided that these services were accessible to catchment area residents and approved by the Secretary of HEW. We believe this authorization should be extended to other mandated services when they are accessible to catchment area residents.

PROBLEMS CAUSED BY A MULTITUDE OF FUNDING MECHANISMS AND PAPERWORK REQUIREMENTS

The multitude of Federal funding mechanisms available to CMHCs and the paperwork required to receive these funds have placed a heavy administrative and financial burden on the

centers, the States, and HEW. In addition, the centers' problems are sometimes compounded by grants not having the same annual termination dates.

As discussed on page 4, Public Law 94-63 authorized six new grant mechanisms to fund the activities of CMHCs. Each mechanism provides Federal funds to support CMHC activities under differing circumstances or for a specific purpose. Four of these mechanisms--initial operations, conversion, consultation and education, and financial distress--are intended to support mental health services delivery activities. Planning grants provide funds to help plan and develop new CMHC programs, while the facilities assistance grant mechanism provides funds to acquire and renovate buildings to house a CMHC.

We found that centers receiving staffing or initial operations grants could receive funds to provide consultation and education services through these grants or through separate consultation and education grants. For such centers these separate grants only add to their administrative workload.

Additionally, two grant mechanisms--CMHC staffing grants and children's service grants--which were authorized under previous legislation are continued under Public Law 94-63 for those grantees who have not completed 8 years of funding. Thus, a total of eight distinct grant mechanisms are currently available under the act to provide financial aid to a CMHC. CMHCs could also receive grants from other programs, such as the alcohol and drug abuse programs, operated by the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse.

Under the previous legislation centers could receive a basic staffing grant and one or more staffing "growth" grants. One center we visited, for example, had five separate 8-year staffing grants. Two of these had August starting dates; the other three started in February, March, and June.

This multitude of grant mechanisms and differing grant periods result in unnecessary paperwork and expense to HEW, the States, and the centers. In addition to the paperwork involved in the initial application, the centers are required to submit annual continuation applications to HEW for all multiple-year grants. Grants management procedures also require that a grantee maintain separate accounting records for each grant awarded and submit separate expenditure reports for each grant detailing how the funds were used.

Thus, the amount of paperwork necessary to comply with HEW grants management regulations increases with the number of grants awarded to an individual CMHC.

An April 28, 1977, Commission on Federal Paperwork report stated that the CMHC grant application package imposes an unnecessarily duplicative paperwork burden on applicants. It further stated that

> "Grant applications are substantial documents not uncommonly running to 100 or more pages. Projects are required to submit seven copies of each application to the HEW regional office, plus at least one copy to each local and State mental health planning agency. Thus a hypothetical CMHC submitting proposals for three grants must submit 21 copies of its proposals to the HEW regional office alone, plus a minimum of six copies to State and local planning agencies.
>
> "The cost of reviewing these applications at the State and Federal levels approaches $122,500 with 12,800 man-hours expended. This figure does not include the cost of reviewing regionally approved applications by both ADAMHA-NIMH central office staff or the National Advisory Mental Health Council.
>
> "The cost and burden of the CMHC grant application requirements fall most heavily upon the applying organization. It is estimated that preparation of the 494 proposals received in the April 1976 grant-cycle costs were $4,000,000. These costs represent a loss of funds intended primarily for patient care. Data received from State, local, Federal and CMHC sources indicate that, in a year containing four grant cycles, the cost to those involved in the application preparation and review process could easily approach $16.7 million.
>
> "Much of the duplicative and cumbersome nature of the CMHC application can be alleviated simply by revising the application package to require a single submission by each center for all grants under the program. This method would save at least $1 million in reproduction costs alone."

The Commission recommended that the Secretary of HEW revise the grant application package to permit a single application regardless of the number of grants sought. The grant application package was revised. An NIMH grants management specialist advised us, however, that the Office of Management and Budget's approval of the revised grant application package had expired before being implemented. Thus, applicants are still required to submit separate applications for each grant requested and for annual continuation grants.

On several occasions during our review, CMHC directors complained that the paperwork and reporting requirements placed on the CMHC staff had increased their administrative costs. The director at one nonfederally funded center told us that one of the major reasons the center had not sought Federal assistance was the amount of paperwork required to maintain compliance with Federal regulations.

Adding to the administrative burden caused by the paperwork requirements is the timing of grant awards by HEW. As required in the legislation, HEW awards grants for 1 year and establishes grant budget periods at the time the initial grant award is made. This budget period is then used for the next continuation grant awarded. The budget periods established by HEW may not necessarily coincide with the grantee's fiscal period, with the budget periods of other CMHC grants awarded to the grantee, or with the budget periods of awards to the grantee from other funding sources.

HEW has been unable to standardize the grant periods to a grantee because of the legislative requirement that grants be for 1 year. HEW could delay awarding a grant to coincide with the grantee's accounting period or anniversary date of other grants, but in many cases, because this delay could be almost a year, this would not be a viable alternative. The separate accounting and reporting requirements of HEW grants management procedures and the necessity to reapply for continuation awards annually would require a CMHC to report detailed expenditure data and estimate future budget data at several points throughout a 12-month period. The following examples were noted during our review.

--At the Northeast Johnson County CMHC in Kansas both the CMHC's and the State's fiscal year runs from January 1 to December 31, and three HEW grants awarded to the CMHC have budget periods of October 1 to September 30 (staffing and consultation and education) and September 1 to August 31 (staffing).

The CMHC director stated that the differences in the grant years and the Federal and State fiscal years make it difficult to project anticipated funding deficits to be used for the following year's request.

--At the Pennyroyal CMHC in Kentucky the center and the State's fiscal year ends on June 30, and four CMHC grants awarded to the center have budget periods of September 1 to August 31 (children's), October 1 to September 30 (consultation and education), and July 1 to June 30 (conversion and distress). The project is required to submit renewal applications and final expenditure reports at three different times during the year.

OTHER PROBLEMS CORRECTED BY 1978 AMENDMENTS

In addition to the previously discussed problems, we noted other problems which have been corrected by Public Law 95-622, including (1) some free standing children's clinics would have been forced to curtail services because Federal funds would have been terminated and (2) funds were lost to the program because no provision for carrying over unexpended grant funds existed.

Free standing children's clinics

In 1970 the Congress enacted amendments to the Community Mental Health Centers Act (Public Law 91-211) which authorized special grants to public and nonprofit private agencies and organizations to help meet the costs of providing specialized mental health services to children. CMHCs and qualified agencies and organizations, referred to as "free standing" clinics, in areas where no CMHCs existed were included among the authorized recipients of these grants. These free standing clinics were required to provide a full range of treatment and followup services for all children and their families in the service area who needed such services, and consultation and education services to all schools and other community agencies serving children in the area. Federal funding support was authorized for a period of 8 years.

Public Law 94-63, as amended by Public Law 95-83, required that within the first three grant periods following passage of the act, free standing children's clinics must have either affiliated with or become comprehensive CMHCs providing all essential services to the entire catchment

area. At the time Public Law 94-63 was passed, 19 free standing children's clinics were receiving Federal grants. We contacted these clinics to determine what impact these provisions had had or would have on their future operations.

Of the 18 clinics which responded to our inquiries, only 5 had become comprehensive CMHCs, and only 2 had been able to affiliate with a CMHC. Another two had submitted applications for operations grants, which had been approved but, as of December 1, 1978, were unfunded. All seven clinics which have existing or pending operations grants had planned to expand their programs even before the law required it. The directors at five clinics stated that Public Law 94-63 had accelerated this expansion. However, one clinic director believed that Public Law 94-63 had forced his facility into too much expansion too soon and described the facility's operation as "chaotic" because of the rapid growth.

At the time of our review, the other nine clinics were in danger of losing their Federal funding eligibility because of Public Law 94-63 requirements. Directors at five of these clinics told us that the loss of Federal funding would require a reduction in clinic staff or a reduction in the amount of services provided. Directors at four clinics stated that the loss of Federal support to their facilities would be so severe that the clinics would be forced to close operations entirely.

By August 1977 two clinics had already ended their grants with NIMH and a third was expecting to do so at the end of its current grant period. Oklahoma operated the clinics that terminated their children's grants. The clinic directors stated that the 12-service model of the Federal program is not consistent with the State's program. Although both clinics have been able to continue providing mental health services, they have reduced the staff and the number of people being served. Similarly, the director of the clinic expecting to terminate the children's grant stated that the loss of Federal support would probably require a 25-percent reduction in the number of children served.

Carrying over unexpended grant funds

Because of the method of awarding initial operations grant funds and because HEW interpreted Public Law 94-63 as not containing a provision authorizing the carryover of unexpended funds to offset the amount of the grant award in the following fiscal year, a substantial amount of funds have been lost to the program and must be returned to the Treasury.

The amount of grant awards under the initial operations, conversion, and distress grant mechanisms, determined according to specific criteria established by Public Law 94-63, limit the grant award amounts to the lesser of (1) the amount that estimated total operating costs of a CMHC exceed the total amount of revenues expected to be obtained from all other funding sources, such as State and local funds, fees, premiums, and third-party reimbursements, or (2) a specified percentage of a grantee's estimated total operating costs during the grant period. These percentages are set out in the law. This financing procedure assumes that Federal funds are the last dollars to be used in meeting a grantee's expenses and is often referred to as "deficit funding."

During fiscal year 1976 HEW awarded about $27 million for initial operations grants to 34 CMHCs. An HEW official estimated that about $5 million, or 18.5 percent, of these funds were returned to the Treasury. If these funds had been available for reprograming, about six new grants could have been funded. As of September 30, 1976, HEW had about $28 million in approved but unfunded initial operations grants.

CHAPTER 3

NEED FOR ADDITIONAL STATE, LOCAL, AND THIRD-PARTY REIMBURSEMENTS TO ASSURE FUTURE VIABILITY OF CENTERS

Adequate State, local, and third-party funding sources must be established if CMHCs are to become financially viable when Federal funding support ends.

At the centers visited, the level of State funding was mixed, local funding in many cases was either minimal or nonexistent, and third-party payments were not being maximized due to the CMHCs' improper planning or barriers beyond their control.

The intent of the Congress is to provide CMHCs with high-level funding in the early years of operation to give them sufficient time to establish other sources of funding. As discussed in chapter 1, Public Law 91-211 extended CMHC funding to 8 years because the Congress found that the 51-month time frame established in prior legislation was not sufficient for centers to establish such sources of funding.

OTHER FEDERAL SUPPORT

In addition to the Federal funds made available under Public Law 94-63, previous CMHC legislation and Federal reimbursements under Medicare and Medicaid, the centers visited received additional funds from HEW and other Federal sources.

We found that significant amounts of CMHC income, particularly in Kentucky, was derived from the social services program under title XX of the Social Security Act (42 U.S.C. 1397). Two Kentucky centers derived 33 and 20 percent, respectively, of their total funds in fiscal year 1977 from title XX. Three other centers, one each in Indiana, Maine, and Ohio received at least 20 percent of their funds in fiscal year 1977 from title XX. In addition, Indiana officials told us that they view title XX reimbursements as a reliable long-range funding source that will allow program expansion.

Many centers also received part of their funds from the Special Health Revenue Sharing program under section 314(d) of the Public Health Services Act. 1/

In fiscal year 1977, 48 CMHCs funded under the Community Mental Health Centers Act also received $7.9 million from the National Institute on Alcohol Abuse and Alcoholism for alcoholism treatment services, and 99 received $13.5 million from the National Institute on Drug Abuse for drug abuse treatment services.

Some CMHCs visited also were receiving or had received funds from the Department of Labor's Comprehensive Employment and Training Act program, the Department of Justice's Law Enforcement Assistance Administration, and the Department of Housing and Urban Development to help develop transitional living facilities.

LEVEL OF STATE SUPPORT FOR CMHCs IS MIXED

From fiscal year 1976 to 1978, State financial support of CMHCs in the 10 States increased about 47 percent.

It should be noted, however, that the cost of health care increased about 19 percent from fiscal years 1976 to 1978. When the States' contributions were adjusted to reflect rising costs, our analysis showed that funding in only four States had increased significantly faster than rising costs. The table on page 32 shows each State's total and estimated per capita funding committed to the CMHC program for fiscal years 1976 through 1978. These figures have not been adjusted to reflect rising costs.

Funding methods vary

We found that the methods used by the States to fund CMHCs varied. For example, both Indiana and Missouri consider State funding "last resort funds." The Missouri centers assume they will receive maximum Federal support and submit a budget to the State on that basis. Indiana funds CMHCs through a deficit financing system. The State allocates funds to each center in an amount equal to projected costs less budgeted receipts from all sources, including Federal grants, patient fees, and local support.

1/Both title XX and section 314(d) funds are subject to limitations and are used to fund CMHCs at the discretion of each State.

Kansas and Maine grant funds directly to each center. The funds each center receives are determined by a formula. Colorado reimburses centers on a unit of service basis. The centers submit monthly vouchers to the State, and payments are made to the centers based on the number of service units provided multiplied by the State reimbursement per unit. New Mexico purchases services from qualified mental health care providers through competitive bidding, and Ohio allocates funds to local boards, which, in turn, reallocate the funds to all mental health care providers, including CMHCs.

State Funding of CMHCs

State	Fiscal year 1976 Total	Fiscal year 1976 Per capita	Fiscal year 1977 Total	Fiscal year 1977 Per capita	Fiscal year 1978 Total	Fiscal year 1978 Per capita
Colorado	$ 9,596,926	3.78	$10,510,466	4.08	$12,373,684	4.72
Idaho	1,197,000	1.47	1,381,000	1.66	2,013,000	2.35
Indiana	11,187,000	2.10	a/18,166,000	3.41	19,328,000	3.63
Kansas (note b)	2,342,472	1.03	c/3,138,233	1.37	a/4,818,951	2.07
Kentucky	4,045,320	1.19	N/A	-	N/A	-
Maine	2,676,209	2.53	2,824,717	2.64	3,594,717	3.31
Massachusetts	14,965,249	2.58	22,998,000	3.97	26,960,000	4.66
Missouri	c/15,746,715	3.30	17,097,097	3.57	20,182,298	4.19
New Mexico	1,733,500	1.51	1,982,800	1.69	2,286,900	1.92
Ohio	d/21,400,000	2.00	d/24,800,000	2.32	d/27,400,000	2.56

a/Budgeted.

b/Kansas data are on a calendar-year basis.

c/Missouri funded only State-operated CMHCs prior to FY 1977.

d/Estimated.

N/A Not available.

Another facet of State support is the State's commitment to the philosophy of Public Law 94-63, especially in terms of services offered. Again, we found that commitment varied by State. A brief description of each State's philosophy follows.

Although Colorado's funding for CMHCs has increased, a Department of Mental Health official informed us that the State's potential to further increase its support is almost nonexistent. The State legislature's position is that it will make no commitment to match the declining Federal share of any services added through conversion or distress funding.

The Idaho legislature supports the concept of CMHCs and has thus far replaced lost Federal funds. One State official told us that he believed the State would continue to maintain what has already been established and will work for balanced funding among the centers.

According to a State official, Indiana has been and will continue to be committed to the Federal philosophy for the CMHC program as set forth in Public Law 94-63. Centers are actively encouraged to apply for Federal funds and to expand to the 12-service model. However, Department of Mental Health officials told us that some flexibility should be allowed. Centralization or sharing of services, especially in urban areas, could lead to more economical service delivery if permitted by law.

The director of Community Mental Health Services stated that Kansas supports Public Law 94-63, but he does not know if the State is willing or able to support the CMHC program without needed continued Federal support.

To date, Kentucky has not been replacing the declining Federal grant funds completely but hopes to increase the State mental health grant allocations. According to State officials, every CMHC should only offer the services justified by community needs and should share services where practical. A special commission, formed by the Governor to study the CMHC program, recommended that the State fund the five basic services and mental retardation services and, after funding these services, give priority to followup and aftercare.

Maine mental health officials stated that they support the CMHC program but questioned the need for all 12 services in each catchment area. The State has been able to replace the declining Federal share of staffing and operations grants and plans to do so in the future, but the State does not plan to cover the loss of conversion grant funds. They believe some services are not self-supporting and should have continued Federal support. The State has contracted with a management consulting firm to develop a more equitable process for distributing State funds and a method to provide uniform accountability for the CMHCs.

Massachusetts' goal is to offer most of the 12 required services in every catchment area. State officials told us that Massachusetts supports most of the concepts of Public Law 94-63. One official believed, however, that requiring all 12 services in every catchment area may not be cost effective and some flexibility should be permitted.

According to the Director of Community Mental Health Services, the Missouri Department of Mental Health is committed to a comprehensive mental health care program, but it is too early to tell if the State legislature fully supports the CMHC program. However, he believes that the program is gaining more acceptance each year and that the legislature is moving toward passage of statewide mental health legislation.

The Secretary of the New Mexico Department of Hospitals and Institutions told us that the potential is good for improved support of the Federal 12-service model. New Mexico's State plan calls for phasing in all 12 services in each of the State's eight catchment areas over the next 3 years.

Ohio appropriations for community mental health programs are provided to county boards. The board directors expressed concern over the CMHCs' ability to continue providing all 12 services after Federal funding ceases. None believed that the Federal model could be supported without Federal funds. Accordingly, we were told that one board will only commit funding for the five basic services. Any additional services would be the responsibility of individual CMHCs.

LOCAL SUPPORT FOR CMHCs HAS BEEN MINIMAL

In addition to State support, local funding support is important if CMHCs are to become financially viable. We found in many cases that local support to federally funded CMHCs was minimal. Of the 19 federally funded centers visited, 8 received no local funding support in fiscal year 1977. In three other cases, local funds made up less than 1 percent of the centers' budgets.

We also visited nine mental health care providers which had not received Federal operations or staffing grants. Of these, three had received less than 1 percent of their budgets from local sources.

The following table shows the percentage of local funds received by the 28 facilities visited.

Percent of Total Budget
Provided by Local Jurisdictions
Fiscal Year 1977

Percent	Federally funded centers	Centers not federally funded (note a)
0	8	1
less than 1	3	2
1 but less than 5	0	1
5 but less than 10	3	2
10 but less than 25	3	0
more than 25	2	3
Total	19	9

a/Two of the nine unfunded centers received a Federal operations grant in November 1977.

Most of the 10 States visited during the review have no mechanism to assure a consistent local funding source. Three States--Indiana, Ohio, and Missouri--had established or were in the process of establishing county tax levies to support CMHCs. Of the three, only the Indiana grant mechanism assured funding. The Indiana mental health law requires each county to levy 4 cents for each $100 of assessed property value for the support of its CMHC. In a few cases, centers have been forced to sue counties to levy the tax, and have won.

Ohio has also given counties authority to levy taxes for support of CMHCs. In that State, however, the levies are passed yearly. The director of one of the mental health boards told us that levies are not consistent between counties, may change from year to year, or may not be passed at all.

Missouri has passed legislation, which allows counties in a catchment area to enact a tax levy for mental health services. However, if passage of the levy fails in any county in the catchment area, it fails for the entire catchment area. During our review the Missouri Department of Mental Health had proposed legislation for a statewide levy that would provide counties with tax revenues to be used for mental health.

In some States, local funding was nearly nonexistent. The three centers visited in Idaho had received no local funding from fiscal years 1975 through 1977. Local support at the two Kentucky centers visited was less than 1 percent of the centers' budgets.

In Missouri and Ohio we found instances where local political problems were impairing the financial viability of federally funded CMHCs. The Southeast Missouri Mental Health Center discontinued its operation as of October 31, 1977, because two of the three counties in its catchment area refused to provide any financial support to the center. The third county, in which the center was located, had been bearing the cost of operating the center, but decided to withdraw that support because of the other counties' refusal to share the cost and because of HEW's insistence that the center serve all three counties and increase the number of available services to meet the requirements of Public Law 94-63.

In Ohio, the Muskingum CMHC was having financial difficulties due principally to a lack of local support. The CMHC serves a six-county catchment area, which is under the control of one regional mental health board. The board and the CMHC have not had a good working relationship. According to the center's director, the board has discouraged the county governments from supporting the CMHC, and its long-range plan is to close the center and establish clinics in each county. Of the five tax levies to be voted on in the fall of 1978, the director expected four to fail, and she stated that without these levies, the CMHC would fail unless the State government intercedes.

We also noted a conflict between the Good Samaritan CMHC in Dayton, Ohio, and the local mental health board. For budgetary purposes, the board had indicated to the CMHC that it would provide a specific amount of State and local funds to support the CMHC's operation during fiscal year 1978. Acting on this information, the CMHC withdrew its application to HEW for a financial distress grant. Subsequently, the board reversed its position and agreed to provide the CMHC with a substantially lower amount of funds. This action precipitated appeal by the CMHC to the State government and has created some ill will between the local board membership and the Good Samaritan CMHC. The CMHC director told us that, without the additional State and local support it had requested from the board, services at the CMHC would probably be reduced or low-revenue providing services, such as consultation and education, would be curtailed, and more staff time would be dedicated to direct services providing greater revenue.

CLIENT FEES AND THIRD-PARTY REIMBURSEMENTS

We found that some centers' receipts from client fees and third-party sources made up a significant portion of total revenue, while at other centers these sources of funds were not being maximized and had little effect on the total budget.

Various factors affected the centers' ability to generate client fees and third-party reimbursements. Centers that provided their own inpatient service or were hospital affiliated apparently are in a better position to maximize reimbursements. Those who could employ full-time psychiatrists and psychologists with doctorate degrees, which could qualify them as providers, were also in a position to generate third-party receipts. Other factors that affected reimbursements were State insurance requirements and Medicaid coverage in the individual States.

The table below shows the percentage of the total budget derived from client fees and third-party reimbursements for the 28 facilities visited.

Reimbursements from Client Fees and Third-Party Reimbursements as Percent of Total Budget for Fiscal Year 1977

Percent	Client fees (note a)	Private insurance (note b)	Medicare (note c)	Medicaid (note a)
0	0	3	13	4
less than 1	2	3	7	2
1 to 5	13	8	3	9
5 to 10	5	6	2	5
10 to 25	5	3	1	4
25 or more	0	1	0	1

a/Figures unavailable at three centers.

b/Figures unavailable at four centers.

c/Figures unavailable at two centers.

Based on fiscal year 1975 data from some centers, NIMH reported that client fees averaged 4.2 percent of the centers' total receipts; private insurance made up 7.8 percent; and Medicaid and Medicare averaged 10.1 and 2.3 percent, respectively. The federally funded CMHCs in our sample received about 22 percent from all four sources combined; the non-funded centers about 16 percent.

Centers' attempts to maximize client fees and third-party payments

The centers visited employ various procedures to maximize payments for services. Among these are sliding fee scales, which are based on clients' ability to pay, intake and screening procedures to determine what insurance coverage each client might have, hiring personnel who could qualify as providers for third-party reimbursement, and placing patients into therapy modes which will both adequately serve each patient's need and offer reimbursement to the center.

Those centers which were hospital affiliated apparently are in the best position to receive reimbursement. One Maine center, which is hospital affiliated, received over 86 percent of its $3 million total income in fiscal year 1977 from patient fees and third-party payments. The remaining income came from Federal, State, and local funding. The center incurred a deficit for fiscal year 1977 of $22,000, which was assumed by the hospital. The controller told us that the center will break even in fiscal year 1978 without Federal funding.

The center director stated that, when the center received its Federal staffing grant, he planned to make the center self-sufficient through third-party payments by the time the grant ended. To accomplish this, the center offers only the five originally mandated services. The CMHC relies on a State-operated agency in the catchment area to offer the other services required by Public Law 94-63.

To maximize third-party payments, the center interviews patients to determine their financial position. The center then tries to obtain as much third-party coverage as possible or places patients into a treatment program which will cover the costs. The controller added that the center has a good relationship with all third-party insurers and communicates frequently with one major insurance carrier to get expanded coverage or payment for new services offered by the center.

A number of other center officials told us that, through improved intake screening and routing of clients, their centers are in a better position to receive third-party benefits. According to one director, since individual therapy stands a better chance for reimbursement than group therapy and is reimbursed at a higher rate, it is used more extensively. However, by using more individual therapy, center manpower is not being used to its greatest potential. He would prefer using more group therapy because a therapist can deal with more clients at the same time.

Two directors stated that they have hired therapists that qualify as providers for Medicare and Medicaid to maximize reimbursements. An Indiana center director said that he is reluctant to hire staff without doctorate or medical degrees because their services are less likely to be eligible for reimbursement. He believes that these restrictions, however, have artificially increased the cost of providing treatment. The director also believes that most future revenue increases must come from third-party sources, coupled with more aggressive collection efforts.

Some centers not maximizing reimbursements

Some centers have not made as great an effort to develop third-party sources of funds. A Kansas center director told us that until mid-1976, when it was in the sixth year of its original staffing grant, the center did not bill private insurance companies because too much paperwork was involved.

A Missouri center's chief accountant said that, although the center is attempting to maximize fees from inpatient services, it is not doing so for outpatient services. She added, that due to lack of administrative staff, the center was unable to screen outpatient clients to determine what insurance coverage may be available.

A New Mexico center revised its method of assigning clients to its professional staff to maximize third-party receipts, particularly those from private insurance companies. This revision was not made, however, until 1977 when the last of its four Federal grants expired and its State and local funding was being reduced.

Barriers to third-party reimbursements

We found that, in many cases, circumstances beyond the control of individual centers could preclude them from obtaining third-party funding as a major source of financial support.

In its 1974 report to accompany S. 66 (see p. 103), the Senate Committee on Labor and Public Welfare was disturbed because only 6 percent of all CMHC income was derived from Medicaid although over two-thirds of the families served had incomes of less than $5,000 a year. The Committee concluded that this was due to many State Medicaid programs not including services provided by free standing clinics. A hospital-affiliated CMHC may share the hospital's provider status, but many CMHCs do not have an inpatient facility and do not qualify as hospitals.

One of the major barriers to CMHCs' increased Medicare participation is the requirement that services be provided by a physician. This requirement eliminates many CMHCs because many mental health professionals, such as psychologists, will not be reimbursed for their services. Another barrier is Medicare's $250 yearly limit on reimbursement for outpatient mental health services and 190-day lifetime limitation on inpatient mental health care provided in psychiatric facilities.

In the 10 States visited, third-party coverage varied. Some States were quite restrictive in who could receive reimbursement for services provided. Other States handled Medicare and Medicaid funds in such a way as to eliminate the centers' incentive to collect them. One State's Medicaid coverage appeared to be quite comprehensive, but its reimbursement rate was established almost 10 years ago and had little relevance to current costs of providing care.

Massachusetts has three types of CMHCs: (1) free standing clinics, which are privately operated, (2) partnership clinics, which under an agreement with the State are staffed by the State and partially supported financially by local governments, and (3) State-operated facilities. Partnership clinics place State Medicaid funds in an escrow account. Each year the account is audited to determine how much should be returned to the State. Usually about three-fourths of each clinic's escrow account is returned. State-owned and -operated centers are required to return all Medicaid reimbursements to the State's general fund. Thus, neither partnership nor State-owned facilities have any real incentive to collect Medicaid reimbursements. Subsequent to our fieldwork, State legislation was passed that would allow mental health facilities to keep all third-party reimbursements.

Idaho centers annually estimate the amount they will receive from Medicaid, private insurance, and individual payments. Any amounts collected in excess of the budgeted amounts go to the State. Thus, there is no incentive for centers to collect more than the budgeted amount. One center director told us that toward the end of the year, if collections are expected to exceed the amount budgeted, the center may delay the billings so that collections will fall into the subsequent year.

In Kentucky Medicaid coverage appears to be quite comprehensive. Eligible providers include those mental health professionals possessing a Master of Social Work degree or above. Services covered include inpatient, outpatient, emergency, partial hospitalization, and psychological testing, as well

as some more specialized services such as detoxification. The State Bureau for Social Insurance reimburses CMHCs for services provided at a flat fee of $16.82 per patient visit regardless of the service provided. This rate was established in 1969 based on the then-average cost of services provided by all CMHCs.

In other States visited, Medicaid coverage was restricted to services provided by licensed psychiatrists or psychologists. In some cases services eligible for reimbursement were limited. For example, in Ohio only CMHCs which are affiliated with hospitals are eligible for reimbursement for inpatient services.

Medicare reimbursements were an insignificant source of income at most of the centers we visited. At 20 of the 28 centers, Medicare receipts amounted to less than 1 percent of total operating income.

EFFORTS TO IMPROVE THIRD-PARTY REIMBURSEMENTS

The recommendations of the President's Commission on Mental Health to improve Medicare and Medicaid reimbursements are discussed in detail in chapter 1. NIMH, recognizing the value of these funding sources, is also working for improvement in this area. An NIMH official told us that the Institute's main strategy is to give CMHCs as much technical assistance as possible to enable them to take advantage of all opportunities for improving third-party reimbursements. The problem, according to one NIMH official, is that not enough HEW regional office personnel are knowledgeable in this area. NIMH has drafted a proposal to use part of the technical assistance funds authorized in Public Law 94-63 to train some private consultants in third-party reimbursements. These consultants would be placed throughout the country to assist CMHCs as the need arises.

NIMH has recently been involved in developing a task force report mandated by Public Law 95-210, the 1978 rural health amendments, to study the cost and feasibility of increasing Medicare coverage to CMHCs. The report was submitted to the Congress on October 10, 1978.

EXPANSION OF SERVICES THROUGH CONVERSION AND DISTRESS GRANTS IS INEFFECTIVE

Public Law 94-63, as amended, introduced two new grant mechanisms to enable CMHCs to expand services--conversion grants and financial distress grants. As mentioned in

chapter 1, conversion grants were designed to assist centers originally funded before the passage of the act to expand their services to the required 12 services. Financial distress grants were designed to assist CMHCs in financial difficulty, which would otherwise be forced to significantly reduce services. These grants were intended by the Congress to assist centers during the transition period between the termination of Federal funding and the improvement of third-party reimbursements.

These mechanisms apparently were ineffective as a means for expanding services on a long-term basis. Some center directors stated that they would have to cut back on services after Federal funding ceased.

A Maine center director told us that he views distress funding as a period for the orderly cutback of services, and regardless of conversion or distress funding, services will have to be cut when Federal funding ends.

One Colorado center closed down its halfway house due to lack of funds even though it received a conversion grant. According to the director, outpatient services will also be reduced when Federal funding ceases. The Colorado State legislature has also stated it would not guarantee replacing Federal funds obtained through the conversion and distress grants.

Another Colorado center had applied for a financial distress grant during our review. The executive director told us the center did not want the distress grant because of the short funding period and because services provided with the grant money would have to be dropped after the grant expired. The center applied for the grant, however, to demonstrate its willingness to work for the funds necessary to meet the needs of the community.

Service cutbacks are commonplace

Over half of the 19 federally funded centers visited have already cut or indicated they will cut services after Federal funding ends. Some center directors stated that the services that are either nonreimbursable or nonincome producing will be cut first.

ABT Associates, under a contract with HEW, visited 28 CMHCs whose Federal funding had terminated, that is, "graduated centers." Their September 1977 report points out that service delivery patterns changed when Federal

funding ceased. Inpatient services rose because they were profitable. Consultation and education services were reduced along with outpatient and outreach services offered at satellite clinics. Emergency services were also reduced either in form or in quantity. Within a year of terminating Federal funding, the CMHC model was in jeopardy at these centers.

ABT concluded that, although the seed money approach had been successful in initiating a viable CMHC program, the Federal Government must continue to "nourish the seeds it plants," by taking an active role in financing the future development of CMHC services. The study recommends that seed money be followed by "maintenance" money, which would be used by mature centers as leverage in negotiating for other funds and as a supplement for basic services which otherwise incur financial losses.

HOW "UNFUNDED" CENTERS OPERATE

We visited nine mental health care providers which had not received a Federal staffing or operations grant through fiscal year 1977. 1/ Some of these centers, however, received Federal funds from other agencies, such as the National Institute on Drug Abuse and the Department of Labor.

The nine centers varied in terms of budget ($100,000 to $3.7 million) and extent of services offered. Two centers offered all 12 required services, while others offered fewer than the original 5 basic services.

These centers encountered many of the same problems as federally funded centers in terms of marshalling reliable sources of continued funding. Local jurisdictions, however, are giving the unfunded centers better financial support than that given to the federally funded centers we visited.

Funding sources

With the exception of Federal staffing or operations grants, funding sources were the same as those established by the federally funded centers. Generally, State and local funding was a higher percentage of the total budget. Local support was under 5 percent of the total budget in four cases but, on the average, was still twice that given to federally funded centers. At half of the locations, State support amounted to over 50 percent of the total budget.

1/Two of these centers received operations grants in fiscal year 1978.

As in the case of the federally funded centers, many unfunded centers received minimal revenue from private insurance and other third-party sources. One center visited did not qualify for Medicare and Medicaid reimbursements due to the lack of a full-time psychiatrist. One other center, although qualified, had not pursued third-party payments as a funding source. The barriers affecting the development of third-party payments as a major source of income, discussed earlier in this chapter, have had a similar effect on those centers not federally funded. Client fees in many cases were also a minor source of income as was the case in many federally funded centers.

Services offered

Services offered by the nine unfunded centers varied from all 12 required services to fewer than the 5 basic services.

A Colorado center, which is receiving nearly 70 percent of its funding from the State, is providing all 12 services. All of these are provided within the catchment area with the exception of inpatient services, since the catchment area does not have a hospital.

A center in Maine was also offering all 12 required services. The director told us, however, that all services were not comprehensive, and specialized units had not been established for children and the elderly. This center received an operations grant in November 1977 and plans to expand services with Federal funds. Funds received from local jurisdictions and charitable organizations over the last 3 years have been averaging about 8 percent of the total budget. The director fears that, with the receipt of Federal funds, these organizations may divert their funds to other health care providers.

Other centers visited were primarily outpatient clinics. Operating on smaller budgets, these centers offered fewer services to their catchment areas. One of these centers, which is offering five services, might have to cut services due to lack of funding. Despite this, the director said that the center had no intention of seeking Federal funds because she believed all 12 services were not needed in the catchment area and that the administrative burden connected with Federal grants was too great. She also believed that the center could not maintain the services after Federal funding ceased.

CHAPTER 4

GRANT REVIEW, APPROVAL, AND MONITORING

As of March 1979, HEW still had not issued final regulations and guidelines to implement Public Law 94-63. We also found that (1) NIMH is progressing slowly in developing standards that could improve the quality of the program, (2) the review of continuation grants by the National Mental Health Advisory Council apparently is unnecessary, (3) the HEW regional offices, with some exceptions, did an effective job of reviewing and approving applications, (4) the regional offices are still having problems making required site visits, (5) centers need more technical assistance, and (6) better reporting procedures are needed to monitor uncompleted construction projects.

STATUS OF PROGRAM REGULATIONS AND GUIDELINES

Although Public Law 94-63 was enacted on July 29, 1975, final program regulations and guidelines had still not been issued as of March 1979. On June 30, 1976, HEW issued interim final regulations governing most grants under the amendments enacted by Public Law 94-63 and governing the development, submission, and approval of State plans for developing comprehensive mental health services. Draft regulations containing more detailed requirements were issued in November 1976, and according to NIMH officials, final regulations have been delayed due to the complexity of both the regulations and the legislation, and the low priority placed on them by HEW. This report discusses the more detailed requirements as contained in the November 1976 draft regulations. Draft program guidelines were sent to the regional offices in April 1977, but an NIMH official told us that final guidelines would not be issued until the regulations were published.

Although the regional officials indicated they had not encountered any major problems because of the lack of regulations and guidelines, officials in six of the seven regions visited stated that the guidance from NIMH headquarters was not specific enough. A lack of guidance on grants management problems was especially noted.

SLOW PROGRESS IN DEVELOPING PROGRAM STANDARDS FOR CMHCs

Public Law 94-63 required the Secretary of HEW to submit a report to the Congress, within 18 months of the date the law was enacted, setting forth (1) national standards for care by CMHCs and (2) criteria for evaluating CMHCs and the quality of services they provided. The Secretary submitted a report to the Congress in February 1977 which contained the "core" of the national standards and their associated criteria for assessing the quality of care in CMHCs. These core standards are based on experience NIMH has gained from monitoring the CMHC program, various aspects of State mental health standards, and the accreditation standards for community mental health programs developed under an NIMH contract by the Joint Commission on Accreditation of Hospitals. The report also pointed out the need to develop adequate resources to implement any standards that would be developed.

NIMH officials told us that although Public Law 94-63 required that standards be developed, the legislation did not require implementation, nor did it give any guidance on how these standards should be used. The officials added that the policy of using a standards approach to improve program content and quality of care is desirable, and NIMH would like to move in that direction. Such standards would be separate from and in addition to the requirements placed on the centers for compliance with the terms of their grants.

One NIMH official advised us that NIMH is currently revising the core standards presented to the Congress in 1977. He added that the standards in their present form are broad, and that NIMH is in the process of making them more specific and better suited to program evaluation. He said that NIMH has proposed to award a contract during fiscal year 1979 to begin field testing the standards to evaluate and further refine them as necessary.

In commenting on a draft of this report, HEW told us that a more accurate assessment of the current status of the standards would be that NIMH is currently exploring the appropriateness of using the set of standards presented to the Congress in 1977, in the context of demonstration studies on Medicare provider status for CMHCs. Field testing and further refinement of the standards may be needed to assure the appropriate use in such demonstrations, and subsequently (in the event of legislative changes granting Medicare provider status to centers), for certification of such centers as Medicare providers.

REVIEW OF GRANT APPLICATIONS BY THE NATIONAL ADVISORY MENTAL HEALTH COUNCIL

Public Law 94-63 required that all applications for CMHC grants be approved by the National Advisory Mental Health Council. The Council was established in 1946 and consists of the Director of NIMH, the chief medical officer of the Veterans Administration or his representative, a medical officer designated by the Secretary of Defense, and 12 other members chosen by the Secretary of HEW. Meetings are held quarterly.

The Council's functions include (1) advising the Secretary and other HEW officials on department policies and programs in the field of mental health, (2) reviewing and making recommendations on applications for research, training, and service grants, and (3) advising the Secretary on regulations required by the Community Mental Health Centers Act.

We reviewed Council actions at seven meetings held from March 1976 through September 1977 on recommendations the regional offices made on about 750 new CMHC grant applications and found that the Council gave special attention to only nine grant applications, of which five were deferred because of various unresolved questions. Of the five grants deferred, four were approved at the next council meeting. In addition to these actions, the Council required region V to add a psychiatrist to its review team and region VII to add a physician, preferably a psychiatrist.

Information was not readily available on the number of noncompeting renewal applications which the Council reviews "en bloc"; however, according to its fiscal year 1979 budget justification, HEW had an estimated 718 noncompeting renewal CMHC grants in fiscal year 1978. For the periods reviewed we found no instances where the Council had disagreed with a regional recommendation and were informed that no grants were ever disapproved.

Applicants for new CMHC grants must file their applications with the HEW regional office serving their area. They are also responsible for submitting the applications to the State mental health authority, the appropriate Health Systems

Agency, 1/ and the State A-95 clearinghouse. 2/ The applicants are encouraged to, and generally do, submit their applications to the regional office for advance review.

Although the procedures vary among the regional offices, the applications are generally reviewed in a two-step process. They are first reviewed by the contracts and grants management staff and the mental health professional staff to assure that the application conforms to pertinent laws, regulations and policies, instructions, and required clearances. The applications are then reviewed by an objective review committee. The Public Health Service Grants Administration manual requires that persons outside the awarding component must constitute at least half of the technical reviewers.

Despite the small number of new grants receiving special attention, the review of grant applications by the Council does appear to serve a useful purpose. It not only provides some assurance that the 10 regional offices are following prescribed procedures, but it also affords the Council an opportunity to know what is going on at the local level. The procedure apparently has not delayed awarding grants.

There does not, however, appear to be such a justification for reviewing continuation grants because of the lack of attention given such grants.

Public Law 95-622 removed the requirement that the National Advisory Mental Health Council review applications for continuation grants except when a grantee requests Federal funding in excess of the amount specified in its original long-range funding plan.

REGIONAL OFFICE REVIEW AND APPROVAL OF APPLICATIONS

We found that the HEW regional offices generally followed required policies and procedures for reviewing and approving applications for CMHC funds. However, one region is currently using a level of grant review that is of questionable value and in another region many problems existed.

1/Health Systems Agencies are organizations responsible for providing health planning and resources development in designated health service areas.

2/The A-95 clearinghouse is a State agency designated with responsibility for reviewing and commenting on applications for financial assistance under designated Federal programs before the applications are forwarded to the responsible Federal agency.

After completion of this process, all applications are forwarded to the National Advisory Mental Health Council with a recommendation to approve, approve with conditions, defer, or disapprove the grant. The regional health administrator has final approval authority but cannot approve any grant not recommended for approval by the National Advisory Mental Health Council. Continuation grants are generally reviewed by regional office staff.

The following describes the grant review process in the regions visited.

--In Region I grant applications are first reviewed for content and completeness. Outside readers, State, and HEW regional and central office officials review the applications and make recommendations to a Joint Staff Conference. During this process applicants are given an opportunity to discuss their applications. The Joint Staff Conference, which is made up of HEW regional office personnel from different Public Health Service programs, including those administered by ADAMHA, reviews and then ranks the applications before they are submitted to the National Advisory Mental Health Council. The latter review, although within accepted grant review policy, appears to be duplicative and of questionable value, because many Joint Staff Conference members were involved in the first review.

--In region IV all CMHC grant applications are reviewed through five-member review committees. These committees include a chairperson appointed by the Regional Health Administrator, a specialist in grants management, a specialist in finance and health economics, a private consultant, and one other member selected by the chairman. The HEW project officer responsible for the center submitting the grant application and any other HEW officials involved in preparing the grant application cannot be voting committee members. They can, however, be nonvoting members as can State, health systems agency, and CMHC representatives. After review, all applications with recommendations to approve, disapprove, or defer are forwarded to the National Advisory Mental Health Council for review.

--In Region V applications are reviewed by grants management personnel and by program specialists. The applications are then reviewed by the Region's Advisory Group which is composed of people chosen for their expertise and familiarity with the CMHC program, including health providers, State officials, and representatives from CMHCs. The advisory group's

recommendations are then forwarded to the national council.

--In Region VI applications are reviewed by regional grants management personnel and by program specialists. The applications are then evaluated by an Ad Hoc Review Panel consisting of three to eight members chosen from each of the States in the region. The members include State and local government mental health professionals, college and university faculty members with mental health backgrounds, and direct providers of mental health care. The grants management staff, program specialists, and the Ad Hoc Review Panel submit separate recommendations to the Regional Health Administrator who forwards the application with his recommendation to the national advisory council.

--In Region VIII applications are first reviewed by grants management and the program division for compliance with applicable requirements. They are then reviewed by the Objective Review Committee, which consists of five members--two from the program branch and three others, including non-Federal employees. Representatives of the State and center are invited to attend the committee meeting. The committee's recommendation is forwarded to the national advisory council.

--In region X, like Region IV, an objective review committee is also used to review grant applications. The minimum number of review members is five. The use of non-Federal reviewers is encouraged. At least half of the reviewers must be from outside the awarding division. The committee makes its recommendation to the Regional Health Administrator who makes the final recommendation to the national advisory council.

--In Region VII new grant applications receive a "professional level" review, a program level review, and review by a Grants and Contracts Review Committee. The professional level review in Region VII is accomplished through an Ad Hoc Review Group consisting of two professional staff members from the regional office mental health staff and two non-Federal persons deemed to be qualified to judge the technical merit of the application. The Ad Hoc Review Group meets with the applicant, State observers, and other parties, such as the Health Systems Agency, and makes its recommendation to the Director, Division of Alcohol, Drug Abuse and Mental Health.

The program level review is made by one of the in-house professional staff members that sat on the Ad Hoc Review Group. As part of this review, the grant application is submitted to at least two of the other three divisions within the Public Health Service for comment. The division review is to insure integration of the various regional programs. Generally, the divisions do not comment on the applications. In addition, the program level review gives consideration to comments by the grants management staff on financial management matters. Any grant conditions desired by the grants management staff must be negotiated with the program division.

Following these reviews, each application is reviewed by the Grants and Contracts Review Committee. This committee was initially composed of the deputy regional health administrator, the directors of five divisions, and the special assistant to the regional health administrator who constituted the voting membership of the committee. Three assistant regional health administrators and the Chief, Grants and Contracts Management Branch were nonvoting members.

As a result of a reorganization, the committee's composition was revised on January 23, 1978, to include the deputy regional health administrator and the directors of the five Public Health Service Divisions as voting members and the region's executive officer and grants management officer as nonvoting members.

The Public Health Service Grants Administration manual provides that either a standing committee or ad hoc committees may be utilized to review grant applications, but not both. Region VII's review system does not comply with the requirement. The manual also requires that the review system set forth the relationship between the review committees and the official with final awarding authority, including the conditions under which the awarding officials can or cannot make an award when the review group has made an adverse recommendation. Such conditions have not been established by region VII.

In addition to the above problem in reviewing and approving grant applications, we found several instances of an inadequate review and negotiation of CMHC budgets and conditions. For example, in June 1977 the region had awarded an initial operations grant totaling almost $578,000 in the first year to a Missouri center without conditions despite the fact that (1) a condition on the third-year continuation staffing grant concerning the CMHC's accounting system had not been

satisfactorily resolved at the time the initial operations grant was awarded, (2) the HEW Audit Agency conducted a review of the administration of developmental disabilities, alcohol, drug abuse, and 314(d) formula grants in Missouri and reported on April 21, 1977, that the center had deficiencies in program management, including accounting, reporting, and payroll distribution, (3) the Grants and Contracts Management Branch questioned the ability of the applicant's accounting system to segregate costs and pointed out the internal audit fundings, and (4) after considerable discussion, the Grants and Contracts Review Committee voted to recommend approval in the requested amount with a condition relative to the various systems and procedures deficiencies. The Notice of Grant Award did not contain such a condition.

MONITORING CENTERS BY HEW AND THE STATES

In our 1974 report on the CMHC program, we reported problems with monitoring centers through site visits because

- --visits were not always made annually as required,
- --problems and deficiencies noted had not been followed up for correction, and
- --staff making site visits often did not include persons having financial expertise.

Monitoring problems were also noted in our 1971 report. In this current review we found that problems still exist in HEW's monitoring of centers.

NIMH has given considerable attention to the need for monitoring CMHCs. It developed a CMHC monitoring package, which was issued to the regions in March 1977 and has had a study group make recommendations for improving the monitoring of CMHCs.

The September 1977 study group report recommended that

- --a new definition be adopted of what the monitoring process should be;
- --every CMHC have a regional office project officer assigned for monitoring and assisting the center;
- --all persons involved in monitoring CMHCs receive adequate training;

--documents used in offsite center reviews to determine compliance should be nonduplicative and impose as light a burden as possible on the grantee;

--an abbreviated instrument be developed and used which would record the presence or absence of the administrative and service requirements contained in sections 201(C) and 206 of Public Law 94-63; and

--a study be initiated (1) to examine the cost and utilization frequency of all the different types of monitoring activities employed by the regional offices in the last 2 years and the extent to which and conditions under which each of these types of monitoring activities results in desired changes and (2) to develop and field test new monitoring techniques as alternatives or supplements to existing techniques.

The Acting Director of NIMH's Division of Mental Health Service Programs agreed with the recommendations, some of which are being implemented.

Despite these efforts we found that (1) annual site visits as required by NIMH are still not always made, (2) participation by grants management officials in site visits is still very limited, (3) in some States mental health agency officials, although invited, often do not participate in site visits, and (4) regions are not always using the NIMH-developed monitoring package. The primary reason for these problems appears to be the shortage of staff to monitor the centers. For example:

--Region I made 26 site visits in fiscal year 1977, but only 5 were considered to be comprehensive visits. A total of 51 visits was planned in fiscal year 1978. An HEW financial expert made 12 site visits in fiscal year 1977, but recently he has been going less frequently because of the limited time available to make such trips. A regional official told us that its seven professional staff responsible for monitoring 58 regional CMHCs was insufficient. He also said that a particular need exists for staff with financial expertise. The region has only one financial analyst who is responsible for reviewing the financial management capabilities of grantees and providing technical assistance for 250 grants.

--Region VI attempts to make annual visits, but because of staff and travel fund constraints visits are usually made biannually. Grants and contracts personnel seldom accompany program officials on site

visits, but we were informed that grants and contracts management staff make separate site visits every 2 to 3 years. The States are encouraged to participate in site visits. Participation by State officials ranged from the situation in Arkansas where State officials accompanied HEW on all 21 visits to centers in that State since July 1975 to the situation in Oklahoma and Texas where Oklahoma officials went on 2 of 8 visits and Texas officials accompanied HEW on 11 of 43 visits. The CMHC monitoring package is not used on a routine basis by the region VI staff. Officials told us that the monitoring package had been used on a trial basis, but was too cumbersome.

--In region VII we found that, according to the site visit schedule, one center had been visited only once--in January 1974. Of 32 other centers reviewed, there was no record of visits to 3; and 23 had not been visited for over a year, of which 5 had not been visited for over 2 years. Regional grants management personnel visited 12 CMHCs in fiscal year 1977. The grants management specialist responsible for the CMHC program told us that he was responsible for over 100 grants, of which about 53 were for about 30 CMHCs. We were told that the lack of staff made it impossible to follow the CMHC monitoring package and that the procedures checklist of areas to be reviewed does not adequately distinguish between serious and less serious deficiencies.

As mentioned, some State mental health officials accompany HEW monitors on almost all visits while others go less often. Of the 10 States visited, we found varying extents to which the States were performing their own monitoring of centers. Colorado appears to do the most comprehensive monitoring and, in addition to HEW monitoring requirements, makes its own site visits and has established its own standards, rules, and regulations.

Public Law 95-622 authorizes the Secretary of HEW to contract with State mental health authorities under which such authorities would monitor, for compliance with the law, CMHCs receiving operations, consultation and education, or conversion grants. The State authorities cannot receive funds, however, to monitor centers operated by the State.

TECHNICAL ASSISTANCE PROVIDED TO CENTERS

Center officials, with few exceptions, who commented on the technical assistance HEW provided expressed satisfaction with it. However, they felt a particular need exists for

more assistance in financial management and improving third-party collections.

We found that the regional offices had established systems for determining the technical assistance needs of the centers and, to the extent that staff and funds were available, the needs were addressed.

INACCURATE RECORDKEEPING AND REPORTING ON STATUS OF CONSTRUCTION GRANT PROJECTS

We found significant variances in program records maintained by NIMH headquarters, the accounting records, HEW regional office records, and information being gathered by an NIMH headquarters architectural engineer. These variances appear to be caused at least, in part, by the failure of the regional offices to closely monitor the projects and provide all pertinent information to NIMH headquarters, and the failure of NIMH headquarters to record all the information that is provided. NIMH officials advised us that because responsibility for administering the grants has been given to the regional offices, NIMH cannot require the regions to give more attention to these grants.

Since fiscal year 1965, when the first construction grants were awarded, HEW has provided about $261.6 million to 576 grantees to help meet the cost of constructing, acquiring, or remodeling mental health care facilities. No new funds have been appropriated for this program since fiscal year 1974, and the final grants were awarded during fiscal year 1975.

In our August 27, 1974, report, we identified various deficiencies in the construction grant program, including lengthy delays in starting construction. During this review we wanted to determine the amount of unexpended obligations still outstanding in the construction grant program and the reasons why these funds have not been expended or deobligated. We first examined the records maintained at NIMH headquarters. Those records showed that as of December 31, 1977, unexpended obligations totaled $68.1 million.

An analysis of open grants and contracts prepared by HEW's Health Services Administration, which performs accounting services for NIMH, showed that as of January 31, 1978, the CMHC construction grant program had an unexpended balance of $33.2 million. This was $34.9 million less than the $68.1 million shown in NIMH headquarters records 1 month earlier.

We attempted to reconcile the differences between the NIMH records and the Health Services Administration records

by comparing individual project balances. We obtained additional information from three HEW regional offices on the current balance in construction grant programs in these regions. We also examined a report prepared by an NIMH official responsible for providing technical assistance and advice on architectural and engineering aspects of construction projects. This report shows the current status of each open construction grant project in terms of its progress in completing the preconstruction and construction phases. We found, however, that these additional sources of information were also inconsistent with the NIMH records. In one instance a construction grant totaling $292,735 had been awarded during fiscal year 1974 and was being carried as an open account by NIMH headquarters, the HEW regional office, and the Health Services Administration. However, the NIMH architectural engineer's report showed that this grant had been deobligated in October 1975. The construction grant program records maintained by NIMH headquarters were so inaccurate and inconsistent with other data sources that we would have been unable to reconcile these records within a reasonable amount of time. Because of these problems we did not attempt to determine why construction grant funds had not been expended or deobligated.

We examined the procedures followed by NIMH headquarters personnel in maintaining the construction grant program records and attempted to determine what specific uses were made of the data in the records. We found that NIMH relies on summary expenditure reports submitted by HEW regional office personnel to update the NIMH records. These reports are accumulated at headquarters for 6 months before the records are updated. We found, however, that in one regional office the expenditure reports were not being forwarded to NIMH headquarters on a routine basis because, according to a regional office official, not all of the bookkeeping tasks were performed through most of calendar year 1977. These tasks were assigned to a regional office employee who, according to the official, only worked part time on NIMH programs and did not have a total understanding of the job. At another regional office we examined documentation showing that expenditure reports had been forwarded to NIMH but apparently had never been recorded on NIMH headquarters records.

We were unable to determine what specific uses are made of the NIMH records. NIMH personnel responsible for maintaining the records told us that the primary use is for internal information needed to monitor the progress being made on open construction grant projects. We found, however, that the architectural engineer in NIMH headquarters responsible for providing technical assistance and monitoring the program obtains his data, on a voluntary basis, directly from the regional offices.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

It has been the intent of the Congress, since the inception of the CMHC program, that the Nation be covered with a network of CMHCs. The Congress further intended that Federal financial support would be provided to assist in the development of necessary services and that such support should be limited in extent so as not to replace State and local funding and responsibility and be limited in duration to allow centers to develop alternative sources of funding.

If this planned network is to be completed within the foreseeable future, either (1) more funds will need to be authorized and appropriated, (2) a limit will need to be placed on the maximum amount of Federal funding available to each center, (3) the number of services required will need to be reduced, or (4) some alternative method of funding, such as increased third-party payments, will need to be found. At the present level of funding, this network will not be completed before the year 2000.

We believe that a center should not be required to offer a service if it can demonstrate to the Secretary of HEW that the service is not needed or is being adequately provided by other organizations in the catchment area. Further, we believe that centers should be given the flexibility to share services, especially in urban areas, if it can be demonstrated that those services can be provided effectively and economically outside the catchment area.

Although Public Law 95-622 has specifically allowed centers, with HEW approval, to offer inpatient, emergency, and transitional halfway house services outside the catchment area, we believe consideration should be given to a similar provision for other services that may be provided more efficiently and effectively outside the catchment area.

We found that requiring free-standing children's mental health clinics to become comprehensive CMHCs or to affiliate with one to continue receiving Federal funds would cause an undue hardship on some of these clinics. Some would have discontinued the services and others would have reduced the level of services. Since the completion of our fieldwork, the Congress has amended the act to eliminate the requirement that these clinics offer the 12 required services or affiliate

with a CMHC. We believe this action should alleviate the problems encountered by these clinics, at least until they have completed their 8 years of eligibility for such grants.

We believe that conversion and financial distress grants are an ineffective means for the development and long-term expansion of services at CMHCs. Nonincome producing or non-reimbursable services added by these mechanisms have been or, according to center officials, will be reduced or eliminated when Federal support ends. Although the Congress has extended the authorization for these funding mechanisms, the legislative committees in both the House and the Senate stated they plan to examine post-8-year-funding mechanisms early in the 96th Congress. We believe that in examining these mechanisms, the Congress should consider whether they should be terminated.

We continue to believe that in some areas, catchment area size limitations have resulted in an unnecessary duplication of services, caused an uneven distribution of services in geographically large catchment areas, and prevented some communities from applying for Federal funds because of the inability to unify the entire catchment area. We therefore believe that HEW should identify these areas with a view toward revising catchment area boundaries in those cases where such a change would eliminate unnecessary duplication of services or give a community, which would not otherwise be eligible, the opportunity to apply for Federal CMHC funds.

We also found communities that could not afford or, because of sparse population, could not economically provide some of the mandated mental health services. In order that these communities can have some mental health services, we believe that consideration should be given to developing a funding mechanism that would allow these communities to provide fewer than the 12 required services.

Action needs to be taken to reduce the paperwork and administrative burden placed on HEW, the States, and the centers caused by the various grants received by centers, the varying ending dates of the grants, and HEW's requirements on applications for new and continuation grants. We believe that the number of grants to individual centers should be consolidated to the extent possible and annual termination dates made as consistent as possible. This should, in turn, allow HEW regional office staff more time to offer more technical assistance and other needed services to the CMHCs due to a lessened administrative workload.

In general, the States included in our review were providing a considerable amount of financial support to the CMHC program. However, this support has, in many cases, merely kept pace with inflation. There has been a considerable variance in the States' approach to the program and their involvement in the operations of the centers. The centers included in our review also received a considerable amount of Federal funds in addition to those received through the CMHC program.

Third-party reimbursements, including Medicare, Medicaid, private insurance, and client fees have generally not provided the level of funding needed to make the centers self-sufficient. The basic problems have been the centers' ineligibility for reimbursement and the centers' failure to maximize their reimbursements.

Many centers visited received less than 5 percent of their total income from any single third-party source; some received less than 5 percent from all third-party sources combined. We believe that the recommendations we have made in previous reports to improve Medicare and Medicaid reimbursements (see p. 61) are still valid. At the same time, we believe CMHCs can and should do more to maximize those third-party benefits which are available. Some centers have been able to improve third-party collections by means of improved intake screening to determine the clients' ability to pay, the amount of available third-party funding, and placing patients into therapy modes, which will both serve the clients' needs and offer reimbursement to the center.

Our review of nine nonfederally funded centers disclosed that these providers are encountering the same difficulties as funded centers in developing a sound financial base. The only major difference appears to be in the level of local support which, in general, was a higher percentage of total receipts at nonfederally funded centers.

We believe that the HEW regional offices, with the major exception of one office, have followed the required policies and procedures for reviewing and approving grant applications. The National Advisory Mental Health Council was required by Public Law 94-63 to review all CMHC grant applications, and we believe the Council's review served a useful purpose in approving grants for initial funding. We believe, however, that a similar review of continuation grants is not warranted, and the Congress has, since the completion of our fieldwork, amended the law to eliminate this requirement.

Another function of HEW regional office personnel is to conduct annual site visits to all CMHCs and to offer technical assistance to CMHCs, when necessary. Generally, we believe that, considering their available resources, HEW regional offices are doing an adequate job in offering technical assistance to CMHCs. Improvements are necessary in CMHC monitoring activities, including the makeup of site visit teams and the timeliness of such site visits. The recent legislative change authorizing the Secretary of HEW to contract with State mental health authorities to perform the monitoring should alleviate these problems somewhat. Because of this, we are not making any recommendations at this time.

Regularly scheduled visits to federally funded CMHCs are very important, especially during the early years of a grant to insure that the centers are properly carrying out the terms of their grants. It is also important that staff with financial expertise be included, where necessary, in the site visit team to assure that the centers have developed an adequate system of controls over Federal resources and are properly following prescribed procedures.

We further believe that, if additional resources cannot be made available to monitor CMHCs, priority should generally be given to newly funded CMHCs unless specific problems are identified in other centers. This review, our prior CMHC program review, and our reviews of individual centers show the need for identifying the centers' management weaknesses early in the life of these multiyear grants.

Although some CMHCs had effective coordination with State mental health hospitals, others had not. If centers are to provide adequate aftercare to released mental patients, improved cooperation and communication is necessary. We also noted a lack of cooperation and coordination with Veterans Administration's psychiatric facilities. We believe the benefits of coordinating with these facilities should be further explored.

NIMH should examine the uses made of the construction grant program records and reports prepared and maintained at headquarters and determine whether these uses justify their continuation. If the records serve a useful purpose, the reporting procedures should be strengthened to assure that accurate up-to-date information on all uncompleted construction projects is available on a continuing basis.

A considerable amount of time, effort, and resources has been expended by NIMH in developing standards for CMHCs, yet none of these has been implemented. HEW should expedite its efforts to prescribe minimum standards, in addition to requirements placed on centers to comply with grant provisions to be met by federally funded CMHCs. By proposing that HEW prescribe and implement standards for CMHCs, we do not mean to imply that NIMH would become a certifying body. The need for CMHCs to meet specified standards will become increasingly important as considerations to make the centers eligible providers under various third-party reimbursement mechanisms, such as Medicare, increase.

Prior GAO recommendations on Medicare and Medicaid reimbursements

In three prior reports we made recommendations to the Secretary of HEW and the Congress of steps we believed should be taken to improve Medicare and Medicaid reimbursement for mental health services. These recommendations which are summarized below are still valid.

In authorizing the CMHC program, the Congress believed that Medicare and Medicaid reimbursements would become significant sources of revenue for CMHCs. This has not been the case as indicated by NIMH statistics and our reviews.

In our 1974 report to the Congress on the progress of the CMHC program, we recommended that the Secretary, if he deemed it appropriate, direct NIMH to work toward expanding coverage provided by third-party payment programs for mental health outpatient services and services provided by non-physicians.

HEW responded that it was appropriate to work toward expansion of coverage and further indicated that the absence of mental health coverage equal to general medical care coverage was a serious economic barrier to the maintenance of available, accessible, and appropriate treatment resources.

Our January 1977 report to the Congress, entitled "Returning the Mentally Disabled to the Community: Government Needs to do More," recommended that the Congress consider amending section 1833(c) of the Social Security Act to increase the amount of outpatient mental health coverage available under Medicare by increasing the $250 limit, the percent of Federal reimbursement, or both, or by authorizing a combined limit on inpatient and outpatient mental health care to encourage outpatient care.

Finally, in an April 1977 report, entitled "Progress and Problems in Treating Alcohol Abusers," we recommended that the Congress explore the need for legislation that would require fuller coverage of alcohol treatment services delivered by programs meeting the Joint Commission on Accreditation of Hospitals' standards for alcoholism programs and by certified counselors under Medicare and Medicaid.

As stated previously, Public Law 94-63 requires CMHCs to offer alcohol and drug abuse treatment services if they are not offered elsewhere in the catchment area. Improvements in Medicare and Medicaid reimbursement for alcohol abuse treatment would also have a positive effect on the CMHCs' ability to become financially viable.

RECOMMENDATIONS TO THE CONGRESS

We recommend that the Congress amend the Community Mental Health Centers Act to:

--Allow the Secretary of Health, Education, and Welfare to waive the requirement for any of the 12 mandated services which a center can demonstrate (1) is not needed, (2) is adequately provided by another organization within the catchment area, or (3) is conveniently accessible outside the catchment area.

--Eliminate the provision for conversion and financial distress grants. If the Congress believes such support is needed, it should explore other methods of providing continuing Federal support.

--Restrict consultation and education grants to organizations not receiving staffing or initial operations grants. Funds for this service could be included in the basic grants.

--Allow HEW to award grants for other than a 1-year period. This change would enable HEW to standardize grant periods and thus reduce the administrative workload on HEW and the centers.

We also recommend that the Congress explore the development of a funding mechanism that would allow communities, unable for various reasons to develop "full service" CMHCs, to provide fewer than the 12 required services. Such a mechanism would allow those communities which cannot provide all the mandated community mental health services to at least provide for their highest priority needs.

We could, if requested, assist the Congress in preparing the legislative language for implementing these recommendations.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW:

--Require NIMH to (1) identify communities that cannot apply for Federal CMHC funding because of their inability to service the entire catchment area or that, because of the size of the catchment area, cannot economically or effectively provide the mandated services and (2) working with the States, revise the catchment area designations to allow those communities to apply.

--To the extent authorized by the legislation, examine the need for and feasibility of consolidating or standardizing the grants and grant periods to each grantee. To reduce the administrative burden on HEW and the centers, all grants to one grantee, where feasible, should have the same accounting period.

--Require all regional offices to follow prescribed procedures for reviewing grant applications.

--Improve reporting and monitoring procedures for the construction grant program.

--Work with the States and the Veterans Administration to assure that CMHCs, as part of their responsibilities, have established coordination, screening, and aftercare procedures with State mental hospitals and Veterans Administration psychiatric facilities.

--Prescribe and implement standards to be met by CMHCs. These standards could be based, at least in part, on those developed by the Joint Commission on Accreditation of Hospitals and those submitted to the Congress by HEW in January 1977.

AGENCY COMMENTS

HEW substantially agreed with the basic conclusions of this report but pointed out that major revisions are forthcoming for the CMHC program. As an outgrowth of the efforts to implement the recommendations of the President's Commission on Mental Health, the Department is proposing new legislation which will address some of our recommendations and, if implemented, will substantially change the CMHC program throughout

the Nation. HEW did not specify which of our recommendations would be addressed by this legislative proposal.

HEW generally concurred with the recommendations to the Secretary and advised us that:

--Communities unable to apply for Federal CMHC funding will be identified in the development and review of the fiscal year 1980 State plans.

--States will be encouraged to revise catchment area designations to comply with the GAO recommendation in the next submission of the State plan. HEW added that the legislation being drafted would relax the present demanding requirements and would also authorize development of services for populations and geographic areas that cannot start a comprehensive program.

--An examination will be completed by the end of 1979 to determine the feasibility and need for consolidating grant periods for each grantee. HEW pointed out, however, that the CMHC legislation specifies discrete grant mechanisms which appear to preclude consolidation. This is in accordance with the intent of our recommendation. One of our recommendations to the Congress (see p. 62) further addresses this problem.

--Regional offices will be instructed to submit, by the end of fiscal year 1979, a description of current application review procedures to ensure compliance with established Public Health Service review procedures.

--Procedures will be developed by December 1979 to improve monitoring and reporting on the construction grant program.

--Regional offices will be instructed to coordinate with the States, within the parameters of Federal-State working relationships and the requirements of the legislation, to develop screening and aftercare procedures with the State mental hospitals. The Veterans Administration will be requested to join in a cooperative effort to develop screening and aftercare procedures between centers and the Veterans Administration psychiatric facilities.

HEW is exploring the appropriateness of using the standards presented to the Congress in 1977. This may require field testing and further refinement. HEW said that the

Department hopes that a demonstration of Medicare cost-related reimbursements to CMHCs planned for fiscal years 1979 and 1980 will yield useful input for formulating standards for reimbursement purposes.

HEW did not specifically comment on the recommendations to the Congress, but officials with whom we discussed the recommendations indicated that they either agreed with them or at least did not oppose them.

BETHESDA COMMUNITY MENTAL HEALTH CENTER

DENVER, COLORADO

The Bethesda Community Mental Health Center serves Denver's southeast section, which has an estimated population of 140,000. The center is affiliated with the Bethesda Hospital.

The center received a CMHC staffing grant in 1969 which expired July 31, 1977. The center has an approved but as yet unfunded distress grant. It provides inpatient, outpatient, partial hospitalization, emergency, consultation and education, specialized services for children, and alcohol treatment services. It has a full-time-equivalent staff of about 37.

Bethesda's sources of funds for fiscal years 1975 through 1977 were as follows:

Source	Fiscal year 1975	1976	1977
Patient fees	$ 78,416	$101,441	$ 91,661
Private insurance	98,232	75,974	105,362
Medicaid	25,866	36,555	9,749
Medicare	4,930	4,360	5,553
Federal CMHC grant	204,660	213,669	213,733
State	517,405	542,981	568,370
Local government	60,420	-	-
Other	6,529	-	11,844
Total	$996,458	$974,980	$1,006,272

SOUTHWEST DENVER COMMUNITY MENTAL HEALTH SERVICES, INC. DENVER, COLORADO

The Southwest Denver Community Mental Health Service, Inc., a private, nonprofit corporation, began operations in 1971 to the estimated 107,000 residents of the southwest section of Denver.

The center has not received any Federal CMHC funds. Although not subject to Public Law 94-63, it provides all 12 services specified in the act. Inpatient services are provided outside the catchment area. The center has a total staff of 60.

The center's sources of funds for fiscal years 1975 through 1977 were as follows:

Source	Fiscal year 1975	1976	1977
Patient fees	$ 28,730	$ 29,805	$ 46,720
Third-party payments (note a)	27,853	33,229	15,020
Federal payments	251,426	188,751	282,256
State	654,952	723,972	790,787
Local government	-	2,067	3,040
Other receipts	456	614	2,381
Total	$963,417	$978,438	$1,140,204

a/Includes private insurance, Medicare, and Medicaid. No breakout available.

WELD MENTAL HEALTH CENTER

GREELEY, COLORADO

The Weld Mental Health Center serves a catchment area which encompasses all of Weld County in north central Colorado. The county has a population of about 112,000 and covers an area of over 4,000 square miles. The center's main office and facilities are in Greeley, and it operates a satellite clinic in Ft. Lupton.

The center had a CMHC staffing grant which expired in 1975. They currently have a children's grant, conversion grant, and distress grant. The center provides all 12 services specified in Public Law 94-63. Inpatient services are provided through contract with a local hospital. The center has a full-time-equivalent staff of 60.

The center's sources of funds for fiscal years 1975 through 1977 were as follows:

Source	Fiscal year 1975	1976	1977
Patient fees	$ 46,323	$ 80,353	$ 123,078
Private insurance	7,933	8,561	12,757
Medicaid	29,351	26,705	24,503
Medicare	2,116	2,498	1,552
Federal CMHC grant	431,730	249,464	288,016
Other Federal funds	17,222	135,581	122,475
State	258,392	405,822	516,723
Local government	12,400	2,800	-
Receipts from other services	18,127	17,562	5,335
Donations	4,326	9,558	7,744
Other income	3,890	6,068	6,464
Total	$831,810	$944,972	$1,108,647

REGION IV MENTAL HEALTH CENTER

BOISE, IDAHO

The Region IV Mental Health Center is operated by the State of Idaho. It serves a four-county area with a population of 190,000. The center's main facilities are in Boise, and it has satellite offices in Mountain Home and McCall.

The center was formed in 1968 when it received its first Federal CMHC staffing grant. They are currently receiving a CMHC "growth" grant. The center provides 8 of the 12 services specified in Public Law 94-63, including inpatient services provided under contract with a local hospital. The center provides no specialized services to the elderly or transitional living facility services. Alcohol and drug abuse services are provided by another State agency. The center has a staff of 36.

The center's sources of funds for calendar years 1975 through 1977 were as follows:

Source	Calendar year 1975	1976	1977
Patient fees	$ 32,187	$ 25,443	$ 32,069
Private insurance	3,038	3,141	2,896
Medicaid	41,093	22,292	41,818
Medicare	-	-	-
Federal CMHC grant	423,360	233,936	278,977
Other Federal payments	14,400	14,317	14,458
State	311,502	511,828	558,603
Local government	-	-	-
Other receipts	-	6	2,021
Total	$825,580	$810,963	$930,842

REGION III MENTAL HEALTH CENTER

CALDWELL, IDAHO

Region III Mental Health Center is a public, State-operated mental health center serving about 116,000 people in a six-county area in southwest Idaho. The center's main facility is in Caldwell. Staff members are also located in Nampa and Payette.

The center is currently in the fourth year of a CMHC staffing grant. The center, at least to some degree, provides 10 of the 12 services specified in Public Law 94-63. Alcohol and drug abuse services are provided by another State agency. The center has a staff of 30.

The center's sources of funds for fiscal years 1975 through 1977 were as follows:

	Fiscal year		
Source	1975 (note a)	1976	1977
Patient fees	$ 8,000	$ 12,597	$ 18,259
Private insurance	-	1,260	2,278
Medicaid	30,000	97,359	95,738
Medicare	-	67	-
Federal CMHC grant	613,397	575,583	641,332
Other Federal payments	-	14,567	25,906
State	184,894	149,694	192,000
Local government	-	-	-
Other receipts	-	10,439	7,641
Total	$836,291	$861,566	$983,154

a/Fiscal year 1975 income was obtained from the center's fiscal year 1976 financial plan submitted to HEW. Fiscal year 1976 and 1977 data were obtained from the "Inventory of Comprehensive Community Mental Health Centers" as submitted to NIMH headquarters.

REGION VI MENTAL HEALTH CENTER

POCATELLO, IDAHO

Region VI Mental Health Center is a public, State-operated center serving a seven-county catchment area in southeast Idaho with a population of about 128,000. The center's main facility is in Pocatello, and staff are also in Blackfoot and Preston.

The center received a Federal CMHC staffing grant in 1969 which expired in December 1977. It receives no other CMHC or other Federal grants.

Region VI provides outpatient, partial hospitalization, emergency, consultation and education, and aftercare services directly and inpatient and court-screening services under contractual arrangements. The center has a staff of 19 plus 3 part-time psychiatrists and 4 work study students.

The center's sources of funds for calendar years 1975 through 1977 were as folows:

Source	Calendar year 1975	1976	1977
Patient fees	$ 13,209	$ 9,090	$ 14,642
Private insurance	6,203	21,803	17,099
Medicaid	43,908	40,774	25,382
Medicare	-	11,856	2,204
Federal CMHC grant	116,683	181,000	181,091
Other Federal payments	-	42,321	14,600
State	227,790	177,711	256,718
Local government	-	-	-
Other receipts	-	830	4,525
Total	$407,793	$485,385	$516,261

QUINCO CONSULTING CENTER

COLUMBUS, INDIANA

The Quinco Consulting Center is a private, not-for-profit agency providing mental health services in five rural counties in south central Indiana. The catchment area has a population of about 141,500.

The center began operations under a different name as an outpatient clinic in 1957. Quinco received a CMHC children's grant in 1971 and a CMHC staffing grant in 1972.

The center offers 10 of the 12 services specified in Public Law 94-63. It provides no court screening or specialized services for the elderly. The center has a staff of 91.

The center's sources of funds for fiscal years 1975 through 1977 were as follows:

Source	Fiscal year 1975	1976	1977
Patient fees	$ 94,186	$ 45,658	$ 57,506
Private insurance	13,318	85,964	107,967
Medicaid	4,872	8,488	10,781
Medicare	-	-	-
Federal grants:			
CMHC	795,360	655,771	535,092
Other	184,350	158,989	14,322
Title XX	-	9,753	102,218
State	481,828	687,093	728,160
Local government	160,317	149,934	181,774
Fees--professional services	2,823	1,356	-
Charitable donations	38,802	-	-
Other	19,338	24,215	26,666
Total	$1,795,194	$1,827,221	$1,764,486

KATHERINE HAMILTON MENTAL HEALTH CENTER, INC.

TERRE HAUTE, INDIANA

The Katherine Hamilton Mental Health Center is a private, not-for-profit agency serving a six-county catchment area in west central Indiana. The catchment area has a population of about 217,000. In addition to its main office in Terre Haute (Vigo County), the center has outreach offices in each of the other five counties.

The center received a Federal construction grant in 1968 and formally opened in early 1971. It received a CMHC staffing grant in 1972, children's grant in 1974, and CMHC conversion grant in 1976.

During our visit Katherine Hamilton was providing 11 of the 12 services specified in Public Law 94-63 and planned to begin offering the 12th--transitional living facilities--in the summer of 1978. The center also offers several developmental disabilities programs for mentally retarded and physically handicapped children and adults. The center has a staff of 213.

The center's revenues for fiscal years 1975 through 1977 were as follows:

Source	Fiscal year 1975	1976	1977
Patient fees	$ 150,542	$ 155,801	$ 164,907
Private insurance	316,323	422,958	457,003
Medicaid	33,968	39,566	45,483
Medicare	117,504	122,261	198,029
Federal grants:			
CHMC	749,856	802,753	894,748
Other	65,342	96,381	54,620
State	535,685	908,413	1,165,571
Local government	163,057	153,792	186,543
Fees--professional services	25,821	38,455	60,255
Charitable donations	-	3,752	6,248
Other	11,120	13,086	12,938
Total	$2,169,218	$2,757,218	$3,246,345

SOUTHERN HILLS MENTAL HEALTH CENTER

JASPER, INDIANA

Southern Hills Mental Health Center is a private, nonprofit agency providing mental health services to five southern Indiana counties with a total population of about 92,000. The center began operations in 1971 as an outpatient clinic. The center has had an approved but, as of January 1978, unfunded initial operations grant. 1/

The center has a staff of 45 and provides inpatient, outpatient, partial hospitalization, emergency, aftercare, and consultation and education services. The center's main facilities are in Jasper, Indiana, and four smaller outreach offices provide services to each of the outlying counties.

The center's sources of funds for fiscal years 1976 through 1978 were as follows:

Source	Fiscal year 1976	1977	1978
Patient fees	$ 27,989	$ 54,727	$ 20,700
Private insurance	15,594	20,994	42,947
Medicaid (note a)	2,968	8,225	9,235
Medicare (note a)	1,484	4,112	4,618
Title XX	-	-	284,254
State	366,546	543,891	506,000
Local government	41,739	93,194	95,000
Other	423	801	100
Total	$456,743	$725,944	$962,854

a/Breakdown between Medicaid and Medicare is estimated on the basis of percentages shown in application for operations grant.

1/This grant was funded in May 1978.

APPENDIX I

WYANDOT MENTAL HEALTH CENTER

KANSAS CITY, KANSAS

The Wyandot Mental Health Center is a private, not-for-profit organization in Kansas City, Kansas. The CMHC began operating in 1953 as a psychiatric clinic for children and was expanded in 1962 to include adults. The CMHC's catchment area is Wyandotte County, Kansas, which has a population of about 178,000. It has satellites in Kansas City and Bonner Springs, Kansas.

The center received a $442,000 construction grant in 1968, a CMHC staffing grant in 1970, and a "growth" grant and a children's Part F grant in 1974. The center currently has a professional staff of 42.

Wyandot CMHC is currently providing 11 of the 12 services specified in Public Law 94-63. It provides no transitional halfway house services.

The CMHC has an agreement with the Rainbow Unit of Osawatomie State Hospital to provide inpatient and partial hospitalization services. One CMHC continuation staffing grant goes directly to the Rainbow Unit to cover the costs of 20 professional staff members. The CMHC also has an agreement with the Kansas University Medical Center to provide emergency services.

The following schedule shows the sources of funding available to the CMHC during calendar years 1975 through 1977.

Source	Calendar year 1975	1976	1977
Patient fees	$ 23,859	$ 26,260	$ 22,141
Private insurance	16,601	36,936	26,967
Medicaid	111,598	163,941	180,961
Federal grant:			
NIMH	551,580	493,985	520,345
Other	-	-	50,195
Other Federal:			
314-d	24,125	12,500	6,771
Alcohol	10,562	-	-
State	38,149	61,940	106,743
Local government	164,775	197,483	189,313
Charitable contributions	5,891	6,000	6,000
Fees--professional services	44,902	40,712	39,303
Other	12,845	16,741	16,035
Total	$1,004,887	$1,056,498	$1,164,774

BERT NASH COMMUNITY MENTAL HEALTH CENTER

LAWRENCE, KANSAS

The Bert Nash Community Mental Health Center is a private, nonprofit center organized to provide mental health services to residents of Douglas County, Kansas. The catchment area designated by the State also includes Linn, Anderson, Miami, and Franklin counties. The center, however, provides no services in those counties. Douglas County has a population of about 56,000.

The center is providing outpatient services in the treatment, diagnosis, and evaluation of mental illness, including a specialized program for children. In addition, the center is providing fragmented consultation and education services and a 24-hour suicide prevention telephone monitoring service. The center is working with the court system to establish an intake-referral system. Bert Nash has a staff of about 21.

The center's funding for calendar years 1975 through 1977 were as follows:

Source	Calendar year 1975	1976	1977
Patient fees	$ 33,566	$ 39,558	$ 38,874
Private insurance	9,450	21,879	20,211
Medicaid	32,558	53,516	54,180
Medicare	389	1,928	1,977
Other Federal:			
314-d	1,269	12,500	1,461
Title VI-CETA	-	-	957
Drug grant	-	-	5,000
Revenue sharing	11,000	18,000	15,500
State	21,365	25,326	29,643
Local government	85,827	88,851	95,460
Fees--professional services	1,254	1,103	4,831
Charitable contributions	4,064	4,940	6,985
Total	$200,742	$267,601	$275,079

APPENDIX I

NORTHEAST JOHNSON COUNTY

COMMUNITY MENTAL HEALTH CENTER

MISSION, KANSAS

The Northeast Johnson County CMHC is a governmental agency whose board consists of 12 individuals appointed by the County Commissioners. The CMHC serves the extreme northeastern part of Johnson County, Kansas. The area has a population of 120,000 and is bordered by Kansas City, Missouri, on the east and by Kansas City, Kansas, on the north.

The CMHC received its first staffing grant in October 1972 and began functioning as a comprehensive mental health center. It received a conversion grant and currently receives an initial operations grant and a consultation and education grant. The center provides all 12 of the services specified in Public Law 94-63, either directly with a staff of about 55 or through contracts. Some of these services are provided outside the catchment area.

The following schedule shows the sources of funding for the CMHC during calendar years 1975 to 1977. It also shows the sources of funding for CMHC patients at the Rainbow Unit of Osawatomie State Hospital.

APPENDIX I

Source	Calendar year 1975 CMHC	Calendar year 1975 Rainbow Unit	Calendar year 1975 Total	Calendar year 1976 CMHC	Calendar year 1976 Rainbow Unit	Calendar year 1976 Total	Calendar year 1977 CMHC	Calendar year 1977 Rainbow Unit	Calendar year 1977 Total
Patient fees	$ 68,685	$ 10,051	$ 78,736	$ 64,931	$ 10,318	$ 75,249	$ 74,577	$ 5,150	$ 79,727
Private insurance	8,220	52,040	60,260	4,985	79,907	84,892	32,055	40,934	72,989
Medicaid	36,307	39,808	76,115	37,801	85,038	122,839	29,917	18,506	48,423
Medicare	-	2,348	2,348	-	14,676	14,676	-	9,716	9,716
Federal CMHC grant	125,688	143,888	269,576	144,724	134,196	278,920	272,208	81,371	353,579
Other Federal payments	8,530	-	8,530	-	-	-	80,140	-	80,140
State	89,003	-	89,003	112,000	-	112,000	136,800	-	136,800
State payment for Rainbow Unit	-	420,036	420,036	-	389,424	389,424	-	a/565,947	565,947
Local government	263,550	-	263,550	267,388	-	267,388	236,327	-	236,327
Fees--professional services	24,816	-	24,816	19,137	-	19,137	17,717	-	17,717
Other	10,812	-	10,812	13,303	-	13,303	7,917	-	7,917
Total	$635,611	$668,171	$1,303,782	$664,269	$713,559	$1,377,828	$887,658	$721,624	$1,609,282

a/Budgeted figure: Actual not available.

NORTH CENTRAL COMPREHENSIVE CARE CENTER

ELIZABETHTOWN, KENTUCKY

The North Central Comprehensive Care Center was established in 1967 as a private, nonprofit organization to provide mental health and mental retardation services to an eight-county catchment area in north central Kentucky. The area is a designated poverty area and has a population of 181,600. The center has its central office in Elizabethtown and operates clinics in seven of the eight counties.

The center completed its 8-year CMHC basic staffing grant eligibility in 1976 and presently receives Federal grants to provide children's services and alcohol abuse services. The center also has a construction grant awarded in 1974, which has not been used because of its inability to raise the required 40 percent match.

To varying degrees, the center provides 11 of the 12 services specified in Public Law 94-63. It has no transitional living facilities. Inpatient services are provided at an eight-bed psychiatric ward in a local county hospital. The center has a staff of about 110.

The following is the center's funding for fiscal years 1975 through 1977.

Source	Fiscal year 1975	1976	1977
Patient fees	$ 18,666	$ 20,444	$ 17,747
Private insurance	16,266	7,804	12,089
Medicaid	199,961	146,654	124,889
Medicare	-	-	-
Federal grant:			
CMHC	597,706	556,175	137,447
Other	212,946	193,929	207,186
Title XX (IVA and VI)	2,731,810	1,500,000	533,596
State	214,609	382,732	428,000
Local government	12,923	5,846	3,000
Donations	25,741	16,292	11,836
Other services and miscellaneous	289,993	165,680	125,264
Total	$4,320,621	$2,995,556	$1,601,054

PENNYROYAL MENTAL HEALTH--MENTAL RETARDATION BOARD, INC.

HOPKINSVILLE, KENTUCKY

The Pennyroyal Mental Health--Mental Retardation Board, Inc., is a private, nonprofit organization established in September 1967. It currently provides mental health services to about 184,000 people in an eight-county catchment area in rural southwestern Kentucky.

The Pennyroyal center has been awarded numerous Federal grants since it began operating. The center completed eligibility on two 8-year staffing grants in 1975 and 1976; it currently has a conversion grant, distress grant, consultation and education grant, and children's services grant. The center also built a 22-bed inpatient unit at the Hopkins County Hospital with a construction grant.

The center provides all of the services specified in Public Law 94-63; however, some of these are provided through contracts or referrals. The center currently has a full-time-equivalent staff of 85.

The center's sources of funds for fiscal years 1975 through 1977 were as follows:

Source	Fiscal year 1975	1976	1977
Patient fees	$ 81,418	$ 98,414	$ 105,477
Private insurance	52,810	47,829	49,429
Medicaid	239,092	241,367	305,081
Medicare	893	724	1,090
Federal grants:			
CMHC	638,635	387,271	224,918
Other	32,821	36,837	32,706
State	124,399	174,411	164,453
Local	-	-	9,000
Title IVA, VI, and XX	353,943	302,464	235,227
Professional services fees	10,806	21,652	24,706
Donations	20,175	20,557	43,018
Miscellaneous income	8,942	23,591	22,728
Total	$1,563,934	$1,355,117	$1,217,833

BATH-BRUNSWICK MENTAL HEALTH ASSOCIATION, INC.

BATH, MAINE

The Bath-Brunswick Mental Health Association, Inc., is a private, nonprofit organization which provides mental health services to a catchment area consisting of 26 cities and towns in parts of 3 counties. The catchment area has a population of about 66,400.

The center received its first CMHC grant for initial operations effective November 1, 1977. The center provides all 12 services specified in Public Law 94-63 although not all are comprehensive and no discrete units have been established to provide services to children and the elderly. The center has a staff of 63.

The center's sources of funds for calendar years 1975 and 1976 and the 10-month period, January through October 1977, were as follows:

	Calendar year		
Source	1975	1976	1977 (note b)
Patient and agency fees (note a)	$151,300	$153,882	$148,076
Federal grant (drug abuse)	-	14,624	24,019
State	421,263	493,078	409,250
Local governments	42,088	35,716	34,504
Donations	16,370	19,000	15,833
Miscellaneous	1,626	2,630	4,075
Total	$632,647	$718,930	$635,757

a/The center did not maintain its accounts in such a way to enable us to determine amounts for client payment, private insurance, Medicaid, or Medicare.

b/January through October only.

MAINE MEDICAL CENTER

PORTLAND, MAINE

The Community Mental Health Center of the Maine Medical Center is a division of the Maine Medical Center. The center provides mental health services to a one-county catchment area, of which Portland is the largest city. The area has a population of about 174,000. The center includes a 32-bed inpatient unit and two outpatient facilities, both in Portland.

The center received a CMHC construction grant in 1966 and a CMHC staffing grant in September 1969. The staffing grant expired in August 1977. The center currently receives no Federal grants.

The center provides inpatient, outpatient, emergency, partial hospitalization, and consultation and education services. Other types of mental health services are provided by the area mental health board.

The center's sources of funds for fiscal years 1975 through 1977 were as follows:

Source	Fiscal year 1975	1976	1977
Patient fees	$ 422,553	$ 330,894	$ 538,580
Private insurance	670,183	1,126,245	1,268,156
Medicaid	505,913	339,674	520,550
Medicare	136,750	155,695	293,547
Federal CMHC grant	193,643	193,643	193,643
Other Federal payments	-	37,310	14,628
Other receipts for services	-	108,172	114,169
State	215,810	180,907	76,600
Local government	24,500	11,939	14,408
Miscellaneous	83,265	6,203	8,881
Total	$2,252,617	$2,490,682	$3,043,162

YORK COUNTY COUNSELING SERVICES, INC.

SACO, MAINE

The York County Counseling Services, Inc., a private, nonprofit organization, serves a population of about 137,000 in York County, Maine, and three small towns in an adjoining county.

The center received a CMHC staffing grant in 1972 and a 2-year conversion grant in 1977. The center provides 10 of the services specified in Public Law 94-63, although some of the services are not considered comprehensive. Inpatient services are provided through contract with a local hospital. A separate consultation and education program is not provided. The center has a staff of 110.

York County's sources of funds for fiscal years 1975 through 1977 were as follows:

Source	Fiscal year 1975	1976	1977
Patient fees	$ 38,590	$ 87,408	$ 37,601
Private insurance	20,515	67,334	35,275
Medicaid	108,416	132,528	90,538
Medicare	10,560	23,439	5,889
Federal grants:			
CMHC grant	439,728	432,857	661,719
Other	108,000	99,143	140,407
Title XX	207,510	459,541	316,698
State	145,055	129,026	137,390
Local government	45,000	73,472	98,095
Other services	59,631	112,780	133,219
Charitable donations	19,760	20,000	20,000
Other	4,512	10,463	20,593
Total	$1,207,277	$1,647,991	$1,697,424

BROCKTON MULTI-SERVICE CENTER

BROCKTON, MASSACHUSETTS

The Brockton Multi-Service Center began operating in May 1975. The center is organized as a partnership between the State, under the authority of the Department of Mental Health, and local interests represented by Brockton Multi-Services, Inc., a private, nonprofit corporation. The center's catchment area in southeastern Massachusetts has a population of about 211,000 people in Brockton and 10 surrounding towns.

The center received a CMHC initial operations grant effective November 1, 1977. The center directly provides 8 of the 12 services specified in Public Law 94-63 and contracts for drug abuse services. The center also has an affiliation agreement with another organization to provide alcohol abuse services. Inpatient services, which are currently being provided outside the catchment area, and consultation and education services are planned. The center has a staff of over 300, of whom 140 are at the Brockton Unit of the Taunton State Hospital.

The center's funding sources for fiscal years 1976 and 1977 and estimated funding for fiscal year 1978 were as follows:

Source	Fiscal year 1976	1977	1978
Client fees	$ 6,400	$ 33,205	$ 35,000
Private insurance	-	10,107	60,000
Medicaid	6,200	9,358	35,000
Medicare	-	-	-
Federal grants:			
CMHC	-	-	578,944
Other	189,000	142,000	173,600
State	1,382,518	3,499,842	4,115,039
Local government	30,000	42,475	32,000
Other	-	12,636	12,851
Total	$1,614,118	$3,749,623	$5,042,434

GREATER LYNN COMMUNITY MENTAL HEALTH CENTER

LYNN, MASSACHUSETTS

The Greater Lynn Community Mental Health Center is a private, nonprofit organization established in 1972 and is affiliated with the Union Hospital in Lynn. The center's catchment area has a population of about 140,000 and consists of five communities north of Boston. The center has received a CMHC construction grant and is in the fourth year of a CMHC staffing grant.

The center provides 11 of the 12 services specified in Public Law 94-63. It provides no transitional living facility services. The center has a staff of 109.

Greater Lynn's sources of funds for fiscal years 1976 through 1978 were as follows:

Source	Fiscal year 1976	1977	1978 (note b)
Patient fees	$ -	$ 4,000	$ 15,900
Private insurance	10,000	100,200	116,600
Medicaid	190,600	188,300	219,600
Less refund to State	-69,500	-164,400	-179,600
Medicare	10,000	39,100	45,800
Federal CMHC grant	856,900	899,300	885,500
State	426,400	660,700	810,500
Local government	-	-	-
Inpatient unit (note a)	-	782,000	868,000
Total	$1,424,400	$2,509,200	$2,782,300

a/Revenues received from Union Hospital for the center's inpatients. No breakdown of the source of these funds is available.

b/Estimated.

SOUTH SHORE MENTAL HEALTH CENTER

QUINCY, MASSACHUSETTS

The South Shore Mental Health Center was established 50 years ago to provide children's mental health services. It is a private, nonprofit organization and operates as a partnership clinic with the State of Massachusetts.

To meet Federal guidelines, the center's catchment area, which consisted of a population of about 375,000 people, was divided into two catchment areas. It was proposed that two centers be established--South Shore Mental Health Center-East and South Shore Mental Health Center-West. Both have applied for but have not received Federal CMHC funds. In the meantime the center has continued to operate as one unit.

South Shore provides 9 of the 12 services that would be required of a comprehensive mental health center. It provides no inpatient, partial hospitalization, or geriatric services.

Funding information was not available for the entire center. However, we were able to obtain the following information on the sources of funds for the South Shore Mental Health Center-West for fiscal years 1976 and 1977.

	Fiscal year	
Source	1976	1977
Client fees	$ 20,034	$ 25,720
Private insurance	5,260	8,104
Medicaid	10,911	16,541
Medicare	-	-
Federal grants	33,125	38,677
State	35,513	61,862
Local government	108,510	110,656
Donations	6,739	1,000
Other income	39,362	50,958
Total	$259,454	$313,518

ST. FRANCIS COMMUNITY MENTAL HEALTH CENTER

CAPE GIRARDEAU, MISSOURI

The St. Francis Community Mental Health Center is a private, nonprofit organization. The center serves a catchment area in southeastern Missouri which encompasses Ste. Genevieve, Perry, Madison, Bollinger, and Cape Girardeau counties. The five-county area has an estimated population of 100,000 and has been designated as a rural poverty area.

The St. Francis CMHC opened in September 1974. A staffing grant, awarded to the St. Francis Hospital as grantee, provided funds to staff the CMHC's operations. The CMHC is presently in the St. Francis Medical Center and is treated as a department of the hospital. The center has a 21-bed inpatient unit and outpatient facilities. The CMHC also operates outreach facilities in four of the five counties. The center currently provides 11 of the 12 required services on an "inhouse" basis. The center provides no transitional living facilities, but the director stated that the CMHC plans to contract for such services. The center has a staff of 28.

The following schedule shows the CMHC's sources of funds for fiscal years 1975 through 1977:

Source	Fiscal year 1975	1976	1977
Patient fees (note a)	$ 15,561	$ 41,838	$ 54,977
Private insurance (note a)	38,564	37,654	42,128
Medicaid (note a)	6,090	29,286	62,008
Medicare (note a)	7,442	100,410	78,510
Federal:			
CMHC grant	b/143,926	227,864	245,600
Other Federal payments	40,538	53,434	40,335
State	-	19,800	19,800
Local government	-	-	-
Charitable contributions	3,628	3,166	1,773
Fees--professional services	30	85	-
Total	$255,779	$513,537	$545,131

a/The center did not segregate these sources of income until July 1, 1977. The figures shown are staff estimates.

b/Excludes $597,195 construction grant.

MALCOLM BLISS MENTAL HEALTH CENTER

ST. LOUIS, MISSOURI

The Malcolm Bliss Mental Health Center serves a catchment area with an estimated 131,000 population in the east central portion of the city of St. Louis. It is a designated poverty area. The center is operated as a public facility by Missouri. Malcolm Bliss is unique; it is both a community mental health center and State mental institution.

Malcolm Bliss received a Federal CMHC staffing grant in 1966 to provide additional staff and services for the catchment area. Those services included 24-hour emergency room services, children's services, a day hospital, and consultation and education services.

In 1969 the center received a "growth grant" to provide staff for five neighborhood "Outreach Service" clinics. The basic staffing grant expired in August 1974 and the growth grant expired in August 1977.

The center currently offers inpatient services, outpatient services, partial hospitalization, 24-hour emergency care, community consultation and education, screening services, precare and aftercare/followup services, and alcohol abuse services.

The center's funding for fiscal years 1975 and 1976, excluding the cost of the State mental facility, were as follows:

Source	Fiscal year ended June 30 1975	1976
Patient fees	$ 2,819	$ 70,388
Private insurance	71,511	59,319
Medicaid	1,837	61
Medicare	100,072	102,160
CMHC staffing grants	400,535	256,104
Other Federal payments	1,968	6,996
State	2,151,228	2,481,808
Local government	-	-
Fees--professional services	7,252	6,021
Other receipts for services	108,198	-
Miscellaneous	18,221	17,611
Total	$2,863,641	$3,000,468

WEST CENTRAL MISSOURI MENTAL HEALTH CENTER

WARRENSBURG, MISSOURI

The West Central Missouri Mental Health Center is a private, nonprofit organization established in May 1971 to provide mental health services to about 100,000 persons in Johnson, Cass, and Lafayette counties in west central Missouri.

The center, which employs a total staff of 12 persons, has not requested Federal CMHC funds because (1) all of the 12 mandated services are not needed, (2) the center could not maintain the 12 services after Federal funding ends, and (3) the Federal paperwork requirements are too burdensome.

The center currently provides an outpatient program of adult services, children's services, alcoholic services, drug addiction/abuse services, and consultation and education services. The center also provides crisis intervention services on an as-needed basis.

The following schedule shows the center's funding during fiscal years 1976 through 1978.

Source	Fiscal years ended June 30 Actual 1976	Actual 1977	Budgeted 1978
Client payment (note a)	$ 6,540	$18,000	$ 24,000
Medicaid	-	-	-
Medicare	-	-	-
Federal payments 314-d	30,242	22,786	10,000
Revenue sharing:			
Johnson County	10,000	8,000	4,000
Lafayette County	5,000	4,000	4,000
State payments (notes b and c)	-	-	55,000
Local government	-	-	-
Charitable contributions	3,000	4,408	3,500
Total	$54,782	$57,194	$100,500

a/These payments include private insurance payments.

b/These funds represent general revenue/purchase of services funds which are Title XX funds that have been earned by the State.

c/In addition to these funds, the State pays the salaries of the center's part-time psychiatrist and two full-time staff members--a community services coordinator and a mental health consultant.

BERNALILLO COUNTY MENTAL HEALTH/MENTAL RETARDATION CENTER ALBUQUERQUE, NEW MEXICO

The Bernalillo County Mental Health/Mental Retardation Center is a public, nonprofit corporation owned by the county and operated by the University of New Mexico. The center's designated catchment area is the western half of Bernalillo County; however, the center has for several years been serving residents of the entire county. The designated catchment area has a population of about 171,500. The total county population is about 365,000.

The center received its initial CMHC staffing grant in March 1967. It subsequently received a construction grant, additional staffing grants, a children's grant, and a consultation and education grant. The center is currently receiving the children's grant and consultation and education grant and has approved but unfunded conversion and financial distress grants.

The center provides 10 of the 12 services specified in Public Law 94-63. It provides no specialized program for the elderly or transitional living facilities. Bernalillo has a full-time-equivalent staff of 439.

The center's sources of funds for fiscal years 1975 through 1977 were as follows:

Source	Fiscal year 1975	1976	1977
Patient fees (note a)	$ 152,000	$ 138,930	$ 236,901
Private insurance (note a)	250,800	229,235	390,888
Medicaid (note a)	125,400	114,753	195,675
Medicare (note a)	44,080	40,299	68,717
Federal grants:			
CMHC	1,164,800	1,038,013	442,895
Other	177,500	147,247	225,918
Other Federal funds	578,300	729,724	723,987
State	1,135,300	1,248,809	1,420,497
Local government	165,000	546,000	462,000
Fees--other services (note a)	187,720	171,436	292,332
Other	211,100	204,739	255,217
Total	$4,192,000	$4,609,185	$4,715,027

a/The center has one account for patient fees and third-party collections. In fiscal years 1976 and 1977, the center provided NIMH with the breakout by source. Since we could not locate similar data for fiscal year 1975, we estimated that year on the basis of the percentages for fiscal years 1976 and 1977.

COUNSELING AND RESOURCE CENTER

SANTA FE, NEW MEXICO

The Counseling and Resource Center began in 1971 as a volunteer effort helping youngsters with drug abuse problems. The center is a private, nonprofit organization, which currently provides mental health and drug abuse services to the residents of three counties in north central New Mexico. The center does not presently serve the entire State-designated, seven-county catchment area.

The center provides outpatient, aftercare, court screening, and drug abuse services. It also provides inpatient, emergency, children's, and consultation and education services to a very limited extent. The center has a full-time-equivalent staff of 28.

During our review, the center had an approved but unfunded Federal CMHC initial operations grant. 1/ As the following schedule indicates, even though the center has not previously received Federal CMHC funds, it has received a significant portion of its funds through various Federal programs. Following are the center's sources of funds for the 9-month period January through September 1975 and fiscal years 1976 and 1977.

1/This grant was funded by NIMH in July 1978.

Source	January-September 1975	Fiscal year 1976	Fiscal year 1977
Patient fees	$ (a)	$ (a)	$ 2,751
Private insurance	-	-	-
Medicaid	-	-	-
Medicare	-	-	-
Other Federal payments	68,803	76,299	130,707
State	27,892	20,608	59,168
Local government	-	b/15,829	b/7,167
Donations	(a)	(a)	1,994
Other	2,667	7,651	1,094
Total	$99,362	$120,387	$202,881

a/Could not be separated. Included in "Other."

b/Primarily Federal revenue sharing funds.

TRI-COUNTY BOARD OF MENTAL HEALTH AND MENTAL RETARDATION TROY, OHIO

The Tri-County Board of Mental Health and Mental Retardation provides mental health services to a three-county catchment area in rural west central Ohio. The population of the area is about 171,200. The Board contracts for the mental health services with clinics in each of the three counties.

The Board receives no Federal CMHC grant funds. Tri-County provides, at least minimally, all the 12 services specified in Public Law 94-63. The total staff for the three clinics is 56.

Tri-County's sources of funds for fiscal years 1975 through 1977 were as follows.

Source	Fiscal year 1975	1976	1977
Client fees, private insurance, and Medicaid (note a)	$ 65,628	$ 60,902	$ 64,534
Medicare	-	-	-
Title IVA and XX	-	23,565	177,516
Other Federal payments	-	976	6,997
State	327,051	320,202	b/368,011
Local government	220,368	295,434	280,131
Charitable donations	11,925	-	-
Other	4,756	15,236	3,852
Total	$629,728	$716,315	$901,041

1/No breakout available.

2/Includes $47,809 State construction grant.

GOOD SAMARITAN COMMUNITY MENTAL HEALTH CENTER

DAYTON, OHIO

The Good Samaritan Community Mental Health Center serves a population of about 190,000 in northern Dayton, Ohio. The center was established in August 1969 as a division of Good Samaritan Hospital and is governed by the hospital's board of directors. The center's full-time-equivalent staff of 125 are hospital employees.

Good Samaritan received a CMHC construction grant, completed the eighth year of a CMHC staffing grant in July 1977, and is in the sixth year of a children's grant. The center provides 9 of the 12 services specified in Public Law 94-63. The center does not provide transitional living facility services. Alcohol and drug abuse services are provided by other community organizations.

The center's sources of funds for fiscal years 1975 through 1977 were as follows:

	Fiscal year		
Source	1975	1976	1977
Patient fees	$ 23,526	$ 30,955	$ 45,923
Private insurance	214,315	387,313	494,962
Medicaid	30,164	122,759	103,522
Medicare	27,345	49,256	62,626
Federal grants	388,485	367,273	326,636
Title XX	-	-	88,050
State (note a)	266,248	303,958	283,925
Local government (note a)	798,743	911,873	851,776
Other	-	-	30,237
Total	$1,748,826	$2,173,387	$2,287,657

a/State and local funds estimated on the basis of 75 percent local and 25 percent State.

MUSKINGHAM COMPREHENSIVE MENTAL HEALTH CENTER

ZANESVILLE, OHIO

The Muskingham Comprehensive Mental Health Center is a private, nonprofit agency providing mental health services to six eastern Ohio counties with a total population of about 200,000. The center provides services from the main clinic in Zanesville, an inpatient unit at a local hospital, and satellite clinics in four of the other five counties.

Muskingham received a CMHC construction grant and at the time of our review was in the last year of a CMHC staffing grant. The center provides inpatient, outpatient, partial hospitalization, emergency, aftercare, and consultation and education services with a staff of about 50.

The center's sources of funds for fiscal years 1975 through 1977 were as follows:

	Fiscal year		
Source	1975	1976	1977
Patient fees	$ 6,500	$ 14,586	$ 49,843
Private insurance	-	9,086	-
Medicaid	-	195	-
Medicare	-	-	-
Federal grants	(a)	190,207	253,608
Title XX	-	-	83,932
State	227,370	199,631	144,943
Local government	373,353	255,011	245,154
Other receipts	-	18,928	2,703
Charitable donations	-	1,000	3,431
Total	$607,223	$688,644	$783,614

a/The center was under suspension in fiscal year 1975 and received no Federal grant funds.

LEGISLATIVE HISTORY OF THE COMMUNITY MENTAL HEALTH CENTERS PROGRAM

The CMHC program as it exists today has evolved through the passage of four major pieces of legislation, beginning in 1963. The major provisions of the legislation and the intent of the Congress are discussed below.

PUBLIC LAW 88-164--MENTAL RETARDATION FACILITIES AND COMMUNITY MENTAL HEALTH CENTERS CONSTRUCTION ACT OF 1963

In response to the President's message, the Congress enacted Public Law 88-164 (77 Stat. 282), which was approved on October 31, 1963. Title II of the act authorized $150 million over a 3-year period for constructing community mental health care facilities. These funds, granted to the States, could be used to cover as much as two-thirds of the cost of constructing such facilities.

Both the House and the Senate reported that pilot programs in community mental health care indicated that the human suffering caused by mental illness could be substantially reduced through establishing CMHCs. These studies also showed that the cost of community treatment was considerably less than the cost of care at a large public hospital.

The House Committee on Interstate and Foreign Commerce report on the legislation stated that, while mental health facilities were eligible for support under the Hill-Burton hospital construction program, the need for general health facilities had been so great that only 3 percent of the grant funds appropriated had been used for mental health facilities. The Committee believed what the need for separate funds for constructing mental health facilities was clear, and was convinced that this new program should be administered separately from the Hill-Burton program so that each program could achieve its respective goals. No construction project could be eligible for support under both programs.

Both the House and the Senate Committees believed that Federal support for constructing CMHCs was necessary if the Nation was to move ahead in combating mental illness. The House Committee made it clear that, while Federal funds would be made available to help create community mental health services, the support must be tailored so as not to

result in the Federal Government assuming the traditional responsibility of the States, localities, and the medical profession for the care of the mentally ill.

PUBLIC LAW 89-105--MENTAL RETARDATION FACILITIES AND COMMUNITY MENTAL HEALTH CENTERS CONSTRUCTION ACT AMENDMENTS OF 1965

Public Law 89-105 (79 Stat. 427) added the authority to make grants to cover a portion of eligible staffing costs for new services at CMHCs. Federal support was limited to 51 months, on a declining percentage basis. Grant funds could support a maximum of 75 percent of eligible staffing costs for the first 15 months and gradually declined to support 30 percent of eligible costs in the last 12 months.

In their deliberations which led to the passage of the legislation, committees in both the House and the Senate believed that funding for staffing grants was critical to enable communities to develop the new services necessary for adequate community mental health care.

Both committees, however, made it clear that the funds authorized in the legislation were (1) to be temporary in nature to give States and local communities time to develop alternative funding sources and (2) to be used to supplement and augment, not replace, existing funds available for community care.

In this regard the House Committee stated:

> "It is clearly the immediate financial problem which is acute and critical for the success of these efforts. It reflects the inherent difficulty in building a broader base for the support of a major public function. Instead of the burden being borne by the States alone, the States and local communities face the task of working out new patterns of responsibility for mental health. It is not the intention of the committee that the Federal Government will assume the traditional responsibility of the States in this field. However, it is the committee's considered view that it is the proper role of the Federal Government to give its financial assistance in this transitional period * * *."

The Committee further stated:

> "The purpose of the bill would not be achieved if funds authorized could be effectively diverted to replace State funds hitherto available for mental health services. * * * Both the existing construction grant legislation and the proposed staffing legislation represent an effort to improve positively the quality of mental health care accessible to the American people and not a shifting of present burdens. The committee accordingly has sought to assure that the funds authorized by H.R. 2985 will be expended for new services which are genuinely new in scope and content and not merely substitutes for old, by placing a 'maintenance of effort' provision in the bill."

Similar language in the Senate report further reinforces the intent of the Congress.

Thus, the Federal role in the CMHC program was established--short term staffing grants authorized on a declining basis, to aid the States in establishing a network of comprehensive community care. Federal assistance was designed to better equip the States in carrying out their traditional roles of caring for the mental health needs of those persons within their jurisdictions.

PUBLIC LAW 91-211--THE COMMUNITY MENTAL HEALTH CENTERS AMENDMENTS OF 1970

The third major legislation affecting the CMHC program was Public Law 91-211 (84 Stat. 54), which extended the maximum period of support to 8 years and revised the schedule of maximum percentages of Federal support to designated poverty areas. The legislation also authorized specialized programs for alcoholism and drug abuse, the mental health of children, and consultation services.

Although prior experience with the program had been encouraging, the House Committee on Interstate and Foreign Commerce believed that the same experience indicated revision was necessary to achieve the ultimate goal of the CMHC program--"the establishment of a network of comprehensive mental health services that will serve the total population of the United States."

The Committee believed (1) the original estimates of Federal financial participation to help get centers underway was too low and that many centers needed assistance over a longer period of time, (2) projections regarding the development of funding resources through Federal health insurance, private insurance, and other third-party payments proved too optimistic, (3) the task of marshalling community support had been underestimated, and (4) earlier projections had failed to weigh the need for greater assistance to disadvantaged communities and the need for specialized programs for alcoholism and drug abuse and for the mental health of children.

The Senate Committee report was silent concerning these issues.

Both the House and the Senate Committees stated that the amendments would not change the basic program goals but were designed to affect operational changes which would liberalize Federal assistance to all communities.

PUBLIC LAW 94-63--AMENDMENTS TO THE COMMUNITY MENTAL HEALTH CENTERS ACT

In January 1975 the Senate Committee on Labor and Public Welfare (now Committee on Labor and Human Resources) unanimously reported S. 66 for further consideration. The proposed legislation contained the provisions of two bills--Nurses Training and Health Revenue Sharing--that had been pocket-vetoed by the President in the previous session of the Congress.

In reintroducing the legislation the Committee stated:

> "* * * S. 66 reaffirms the Committee's intent that the CMHC program be continued and expanded until every Community in our nation receives these services. The Administration continues to insist that this program is a 'demonstration program,' which should be phased out once it has shown that this new form of health service is effective. In fact, since the inception of the program, this Committee and the Congress have made it clear that CMHCs should eventually be made available, with federal support, to every community in our nation. * * * The Committee believes that the Administration's agreement that the CMHC is a successful approach

APPENDIX II

to providing mental health services is in fact an argument for continuing toward our original goal of a nationwide network of CMHCs."

In June 1975 the House passed legislation that was nearly identical to S. 66, as reported out by the Senate Committee.

Both the House and the Senate Committees believed that 11 years of experience with the CMHC program indicated that substantial changes were necessary and addressed the following issues:

--The need to increase the number of centers until the national goal is attained.

--The need to establish national standards for centers, based on previous experience, and to require centers to provide more comprehensive services.

--The need for changes in the program to encourage self-sufficiency.

--The need for more comprehensive planning and evaluation of services, both at the Federal and catchment area levels.

--The need for a separate program for consultation and education services.

The provisions of Public Law 94-63 are discussed in more detail on page 3.

Senate Bill 66 was passed by both Houses and was sent to the President for signature on July 16, 1975. On July 21, 1975, President Ford vetoed the bill stating:

"Apart from its excessive authorization level, S. 66 is unsound from a program standpoint. In the area of health services, for example, the bill proposes extension and expansion of Community Mental Health Centers projects which have been adequately demonstrated and should now be absorbed by the regular health services delivery system. * * *"

The President's veto was overridden by the Senate on July 26, 1975, and by the House on July 29, 1975. With this action, S. 66 became Public Law 94-63 (89 Stat. 308).

Title III of Public Law 95-83 (91 Stat. 387), the Health Services Extension Act of 1977, extended the authorization for the CMHC program through September 30, 1978, and Public Law 95-622 (92 Stat. 3412), the Community Mental Health Centers Extension Act of 1978, extended the program through September 30, 1980.

APPENDIX III

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

MAR 21 1979

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled "Legislative and Administrative Changes Needed in Community Mental Health Centers Program." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED "LEGISLATIVE AND ADMINISTRATIVE CHANGES NEEDED IN COMMUNITY MENTAL HEALTH CENTERS PROGRAM"

General Comments

We are in substantial agreement with the basic conclusions of this draft report. It should be recognized, however, that major revisions are forthcoming for the Community Mental Health Centers (CMHC) Program. Our comments apply to existing CMHCs. As an outgrowth of the Department's efforts to implement recommendations of the President's Commission on Mental Health, the Department is proposing new legislation (the Community Mental Health Systems Act) which will address a number of the draft report recommendations. If implemented, it will substantially change community mental health programs throughout the Nation.

GAO Recommendation

We recommend that the Secretary of HEW:

(1) Require the National Institute of Mental Health to (a) determine those instances where communities are unable to apply for Federal community mental health center funding because of the inability to service the entire catchment area or where because of the size of the catchment area it would be uneconomical or ineffective to provide the mandated services and (b) working with the States, revise the catchment area designations to allow those communities to apply for Federal CMHC grant funds.

Department Comment

(a) We concur. The instances where communities are unable to apply for Federal community mental health center funding will be identified in the development and review of the fiscal year 1980 Community Mental Health Center State Plans.

(b) We concur. Although State authorities designate the catchment areas, the present National Institute of Mental Health (NIMH) policy provides for flexibility in awarding Federal CMHC grant funds to communities which do not meet the population requirements. Present catchment area populations vary from approximately 23,000 to approximately 350,000. Waivers of the 75,000 to 200,000 population requirement are made on a case-by-case basis and presently more than 15 percent of funded catchment areas have population waivers. Where population size remains a problem, States will be encouraged to revise catchment area designations to comply with this recommendation at their next submission of the State Plan.

In addition, we are in the final stages of drafting legislation for the Community Mental Health Systems Act to be effective not later than fiscal year 1980. A major provision will recognize and enable the continuance of comprehensive community mental health centers, with some relaxation of present, very demanding requirements, while also authorizing development of services for populations and geographic areas that cannot launch a full-scale CMHC program.

(2) To the extent authorized by the legislation, consider the need for and feasibility of consolidating and/or standardizing the grants and grant periods to each grantee. To reduce the administrative burden on HEW and the centers, all grants to one grantee, where feasible, should have the same accounting period.

Department Comment

A careful examination will be conducted by NIMH and completed by the end of calendar year 1979 to determine the feasibility and need for consolidating grant periods for each grantee. However, the existing CMHC Act specifies discrete grant mechanisms which may preclude consolidation.

(3) Assure that all regional offices are following required procedures for reviewing grant applications.

Department Comment

We concur. We are pleased to note that GAO concludes that our regional offices (with one exception) have followed required policies and procedures for reviewing and approving grant applications. Nevertheless, we will require the Regional Health Administrators to submit a description of current application review procedures in order to insure compliance with established PHS review criteria. This will be accomplished by the fourth quarter fiscal year 1979.

(4) Improve reporting and monitoring procedures for the construction grant program.

Department Comment

We concur. Procedures will be developed to improve monitoring and reporting on the CMHC construction grant program. This will be accomplished by December 1979.

(5) Work with the States and the Veterans Administration to assure that CMHCs, as part of their responsibilities, have established coordination, screening and aftercare procedures with State mental hospitals and Veterans Administration psychiatric facilities.

Department Comment

We concur. The Regional Health Administrators will be instructed to coordinate with the States, within the parameters of Federal-State working relationships and the requirements of the CMHC Extension Act of 1978, to develop screening and aftercare procedures with the State mental hospitals. The Veterans Administration (VA) will be requested to join in a cooperative effort to develop screening and aftercare procedures between CMHCs and the VA psychiatric facilities.

(6) Prescribe and implement standards to be met by community mental health centers. These standards could be based, at least in part, on those developed by the Joint Commission on Accreditation of Hospitals and those submitted to the Congress by HEW in January 1977.

Department Comment

It is important to distinguish between the type and level of standards used to (a) monitor program performance which should be demanding but allow for a range of program behavior, and (b) certify CMHCs as recipients under various reimbursement mechanisms. With respect to the former, NIMH is currently exploring the appropriateness of the set of standards presented to the Congress in 1977. This may require field testing and further refinement. With respect to the latter, the Department hopes that a demonstration of Medicare cost-related reimbursement to CMHCs planned for FY 1979 and 1980 will yield useful input for formulating standards for reimbursement purposes.

Technical Comments

The statement on Page iv of the draft report that grantees are required to submit separate applications for each of the eight types of grants authorized under the Community Mental Health Centers Act, resulting in significant administrative and financial burdens, is somewhat misleading. 42 CFR 54.106 as promulgated on June 30, 1976 (41 F.R. 26906, 26910) provides that any application for a grant under the Act may comply with any requirement relating to the content of that application by incorp-

orating by reference portions of the content of a previously filed application for a grant under the same section or any other section of the Act and may indicate changes in the information contained in the previously filed application. This provision is obviously aimed at reducing the administrative and financial burdens cited in the draft GAO report.

The statements on page vii and page 75 of the draft report to the effect that HEW has issued only draft regulations for the implementation of Pub. L. 94-63 are inaccurate. On June 30, 1976, the Department promulgated (41 F.R. 26906) interim final regulations containing (1) general provisions governing all grants under the amendments enacted by Pub. L. 94-63, except grants for rape prevention and control, and (2) provisions governing the development, submission, and approval of state plans for the development of comprehensive mental health services under the amendments enacted by Pub. L. 94-63. The GAO draft report makes no mention of these interim final regulations which have the force of law, but rather refer only to the proposed regulations setting forth more detailed requirements for the implementation of the amendments enacted by Pub. L. 94-63 which were published in the Federal Register as a Notice of Proposed Rulemaking on November 2, 1976 (41 F.R. 48242).

Page 8a (last paragraph) of the draft report states in pertinent part:

> "Centers, in certain situations, may retain a portion of unused funds provided they can demonstrate to the Secretary that these funds will be used to improve or expand service delivery, increase the number of patients they are able to serve, modernize their facilities, improve program administration, or establish a financial reserve to offset the future decrease in federal funding." (Emphasis added.)

The underscored reference to unused funds should be clarified since it may be incorrectly interpreted as referring only to unused grant funds. Under sections 203(c) and 203(e)(1) of the Act, as amended by Pub. L. 95-622, a community mental health center may retain up to 5 percent of the amount by which the total state, local, and other funds and of the fees, premiums, and third-part reimbursement collected in that year, plus the amount of the grant received under section 203 of the Act, exceed the center's costs of operation, if it is demonstrated to the Secretary that this amount will be used for the purposes listed in the above quote.

APPENDIX III

The discussion on pages 45-46 is confusing because: (a) there is no reference to sections 203(b)(1) and 203(e)(1)(B) of the Community Mental Health Centers Act, as amended by Pub. L. 95-622, under which grant funds which have not been obligated by a grantee during the one-year grant period may be carried over for use by that grantee in a succeeding year as part of a continuation grant awarded for the succeeding year; (b) there is no explanantion of the relationship between the "deficit funding" concept, referred to briefly on page 45, and the carry over of unexpended grant balances; and (c) the paragraph on page 46 discusses the apparent need for authority for "reprogramming" unexpended grant balances for award to new grantees in a subsequent fiscal year (the Act has never authorized this practice) rather than any need for the authority to carry over unexpended grant balances for use by the same grantee as part of a continuation grant awarded for the next year (that authority is provided by Pub. L. 95-622 as noted above).

(102519)

*U.S. GOVERNMENT PRINTING OFFICE : 1979 O - 620-167/144

AN EQUAL OPPORTUNITY EMPLOYER

UNITED STATES
GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE,$300

POSTAGE AND FEES PAID
U. S. GENERAL ACCOUNTING OFFICE

SPECIAL FOURTH CLASS RATE
BOOK